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Protective Services For Adults

This document on Protective Service for Adults is being sent to you by the Administration on Aging, Department of Health and Human Services, Washington, D.C. We believe that you will find it a useful tool in initiating, modifying, or expanding protective services for aged and other adults in the communities you serve.

Protective Services For Adults

A Guide to Exemplary Practice
in States Providing Protective Services
to Adults in OHDS Programs

by James J. Burr, Director
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The Administration on Aging
Office of Human Development Services
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Preface

This monograph brings together, for the first time, States' efforts to define and set standards for Protective Services for adults, including the aged, in public social service programs.

Social and legal interventions initiated or carried out by States themselves or under contract with others or referred to other agencies are described. These interventions are carried out under State law, policies and practice.

Exemplary practices carried out by States in implementing policies or standards are highlighted, as well as some issues confronting States in providing protective services to adults in their service program.

The document is enriched by incorporation of appropriate reference to protective practice in law, medicine and social work as appropriate and from the private practice sector.

This monograph is particularly directed to those officials in State Departments and their local counterparts concerned with providing protective services to or on behalf of adults, including older and disabled persons. Its purpose is to assist these State officials in improving their protective services to these, the most vulnerable members of the human family.

Lennie-Marie P. Tolliver

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Commissioner on Aging

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Chapter I

Introduction to the Monograph

This monograph reports a study of the current practices of states in providing a program of public protective services to adults. Those state programs considered exemplary are reviewed and drawn up as a guide for future state program development.

The changing patterns of family life in America in the 80's, and the recognition that by the end of this century the aged in this country will have doubled their population and will represent almost a third of our total population, are forces which must be considered by public agencies serving older persons and others who may need protection. Information on other adults 18 and over needing protection is not as easy to come by although protection for this group is equally needed.

The reliance which current values place on families and friends, impersonally called an informal support system, as the normal and principal resource in protection of adult individuals over 18 years, appears overrated. The willingness and ability of family members to provide support, financial or social, is being questioned as children with older parents face the reality of their own immediate familial responsibilities and their own aging.

This monograph is concerned with State and local public and private social service agencies and their responsibilities in providing protective services to and on behalf of adults now, and in the forseeable future.

Thus, it is addressed to those Administrators at the State and local level who are responsible for managing public social service agencies and to Executives of private Social Service agencies as well. It contains guidelines related to the provision of adult protective services, as defined by States in their statutes and/or service manual or policy materials which form the basis for this document.

The guidelines consist of exemplary practices drawn from States' policies on adult protective service which are replicable and thus useful to other States. Throughout the document, the States are extensively quoted. States can look to the experience and expertise of their peers and draw from their experiences in developing, initiating or expanding their own policies and procedures for carrying out adult protective services.

Where indicated, the experience in the field of social welfare, the law and medicine is drawn upon to enrich this document. Protective services for adults is, after all, a very complex service program which by its very nature involves these components.

This monograph is also addressed to State and local managers concerned with the planning function, program development, staff development, and the service delivery functions, and the costs and benefits associated with them.

The role of States and their local counterparts—county departments of social services—are detailed. Social and legal interventions used by States in providing protection to adults with varied problems and needs are described. Ths costs of carrying out these services are also considered. Finally, some major issues in the protective services are discussed.

While this document is addressed to public social services it will be useful for the private sector. The private sector has an innovative but equally arduous role and responsibility in the development of protective services for the elderly and other adults in their programs since considerable numbers are ineligible for public social services because of their income.

Family Service Agencies over the past two

decades have carried out innovative demonstration projects utilizing a variety of public and private funding sources. Such demonstrations have been replicated in a number of ongoing service agency programs.

These demonstrations have shown that social interventions, usually casework services in so-called protective service cases, could be undertaken and the responsibilities implied in such interventions could be assumed by private voluntary social service agencies.

The early efforts of the Benjamin Rose Institute, Cleveland, Ohio, the United Charities of Chicago, Illinois, and the Sheltering Arms in Houston, Texas in the '60's demonstrated as part of a protective intervention that a petition for observation of a client at a public mental hospital could be initiated by a social worker in a private voluntary agency. This could be done when a client's medical statement pronounced him mentally ill and in need of hospitalization and observation in instances "where there are not relatives or where relatives are unwilling to act." The Agency could, for example, petition the Court for appointment of a guardian in order to protect the possessions of a client.

Most private voluntary social service agencies carrying out protective services for older persons utilize appropriate professionals as consultants when necessary—physicians, nurses, lawyers, other social workers, psychiatrists. Written agency policies guide staff of these agencies in providing protective services to their clients.

It is evident that the background materials quoted reflect demonstrations occurring in the late '60's and early '70's*. Unfortunately there are no more recent national data indicating the extent of protective services programs under non-profit voluntary agency auspices. A study needs to be undertaken to determine the scope and extent of protective services nationwide carried out by social service agencies in the private sector today to determine if the initiatives commenced in the '60's and the early '70's are being carried out today.

*For further information refer to. *Protective Services for Older People*, Lehmann and Mathiasen, NCOA Press 1963, pp 146 ff; *Guide to the Development of Protective Services for Older People*, Hall, Mathiasen and Ross, Charles C. Thomas, Publisher, 1973, pp 23 ff; and "Protective Services for Older People—Findings from the Benjamin Rose Institute Study" in *Social Casework*, October, 1971, Vol. 52, No. 8, pp 483 ff.

Adult Protective Service is a social service with a potential for the use of legal authority. For this reason it is at once a powerful, unwieldy and somewhat dangerous process while it provides an anticipated opportunity for an agency to exercise social intervention to protect impaired individuals from harm. When such interventions cannot achieve expected results the agency can use legal interventions. These are powerful protective instruments but they have a serious drawback for the individual who is "protected". When exercising such interventions it is crucial to avoid denying a citizen his/her basic freedoms while providing protection from harm. The implications of this issue will be discussed in Chapter V of this monograph.

Public Adult Protective Service was identified as a universal service under Title XX of the Social Security Act for adults, without regard to income, prior to the initiation of the Social Services Block Grants in the 1981 Federal laws.

Adult Protective Service is neither to be confused with "in home" services *per se* (although adults may be "protected" in their own home just by being there), nor identified as "long term care" (although "protection" is available at any point in the continuum of living between well being and mental illness, particularly in crisis situations). Nor is this service exclusively a legal service.

For purposes of this document Adult Protective Service is a social service with medical and legal components, provided to individuals with certain identifiable characteristics who are found in circumstances and situations which are considered to be harmful or dangerous. They are generally administered by a social caseworker who acts as the coordinator of these diverse services and is the central direct service worker with the individual clients. Such individuals may have, on occasion, no one to assist them responsibly and they must be removed as quickly as possible from such situations for their own or others' "protection"; or conversely the situations and circumstances need to be modified, removed or alleviated for the same purpose.

The law is involved in protective service in every State at two levels—programmatic and

individual service. Legal authority is first required to carry out a protective service program on behalf of impaired individuals unable to manage independently and who desire help. At the second level, States need legal authority to intervene in the life of individuals adjudged so impaired that they are unable to make decisions which protect their own welfare. In this monograph the phrase "legal intervention" is used to mean the second level, establishing legal incompetence as the basis for action on their behalf with or without their consent or over their objections. This subject will be considered further in Chapter IV in its relation to social intervention.

The citations referred to in the text are identified at the end of each chapter. The specific citations, by State, identify the section and sub-section of the State manual from which the reference in the document was taken.

For convenience, from time to time, "Adult Protective Service" is used in lieu of the full title.

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Chapter II

Protective Services For Adults—Definitions, Purposes, and Client Characteristics

Definitions

Defining adult protective service is troublesome. This stems from the fact that many kinds of discrete public social services are provided to meet the goal of protection. The individual service components in the protective service "package," themselves, are not essentially "protective" in the special sense of a comprehensive service. Homemaker services, for example, may be provided as part of a cluster of services to a physically and/or mentally impaired individual to meet the goal of protection. Homemaker services, however are not alone, a protective service. The provision of legal services is not normally "protective", although some legal procedures (guardianship) are essentially protective. Medical care is preventive, supportive and therapeutic but not always "protective" in the sense of taking over responsibility for the welfare of an individual helpless to direct his own life.

A psychiatrist may testify in court that a person is ill. This is not necessarily "protective". However, when he testifies in a legal commitment procedure that an individual is incompetent because of a mental disease, dysfunction or defect and requires a protective institutional placement, then this is a "protective service" as understood by state personnel. The individual responsible for the client's overall management and the coordination of all aspects is the caseworker.

Definitions of adult protective services are present in State statutes, service manuals, and in Comprehensive Annual Services Plans (CASP) in States providing social services under Title XX of the Social Security Act. All States indicate that an adult is anyone over 18 years of age. Several States limit adult protective services to the elderly. Other States in their service manuals define protective services for "incapacitated persons" (i.e. the developmentally disabled).

A number of States indicate that adult individuals who are in fact abused, neglected or exploited by others should be provided protective services. The need for protection is based upon the adult individual's vulnerability to abuse, neglect or exploitation. This vulnerability is frequently due to limitations--mild to severe—in physical or mental functioning or to incompetency due to mental illness.

Some States define protective services as "those activities which are brought into play to prevent individuals from being harmed or harming others, or who are in hazardous situations and need to be protected."

Several States in their definition of adult protective services place the emphasis on individuals who are unable to care for themselves and who have no one ready, willing or able to assist them responsibly and thus need protective services. This implies that a number of adults, particularly the elderly, have little expectation of assistance from their children or other family members who cannot assume responsibility for their protection.

One State (New York) in an elegantly phrased definition identifies protective services as "a system of care." This notion reflects the sense of the definition of protective services for adults in the Federal Regulations under Title VI of the Social Security Act (Grants to States for Services to the Aged, Blind or Disabled) which was replaced by Title XX (Grants to States for Services) in October 1975.

The Federal definition in Title VI follows:

> "Protective services means a system of service (including medical and legal services which are incidental to the service plan) which are utilized to assist seriously impaired eligible individuals who, because of mental or physical dysfunction, are unable to manage their own resources, carry out the activities of daily living, or protect themselves from neglect or hazardous situations without assistance from others and have no one available who is willing and able to assist them responsibly." (Section 45 CFR Part 222.73)

The New York State definition of adult protective services follows:

> "Protective services for adults is a system of care which includes the availability of a constellation of services brought to bear individually or in concert upon a problem situation of an adult requiring a planned approach of intervention. As a preventive, supportive and surrogate service, it is aimed at maintaining individuals in the community as long as feasible rather than institutionalizing them, though, in some cases, the latter may be necessary. More specifically it can be stated that a protective service system aims at the prevention, reduction or elimination of neglect, exploitation or crisis breakdown through the provision of services appropriate to the individual's needs which will strengthen his capacity to function and maximize his ability at self direction."[3]

Appendix U presents still another definition of protective service, including components and preventive and protective aspects. In the face of somewhat diverse emphasis some analysis of these definitions is needed.

Some of the variables in attempting to define adult protective services are: (1) individual functioning, (2) the circumstances or situations in relation to the individual's behavior, (3) action by a third party detrimental to the individual, (4) the problem that brings them to agency attention.

Individuals are ordinarily expected to carry out the normal activities of daily living without help from others. If there is a functional inability to carry out these activities this is considered to be a measure of incapacity. An individual who neglects personal hygiene, lets living quarters become filthy, neglects to protect his/her money or assistance check over a long period of time, will sooner or later be considered a suitable candidate for protective services because of a manifest functional impairment.

It is unsuitable behavior in the circumstances. It reflects a mode which is inconsistent with the normal conduct in our society. It is, in short, an example of mental or emotional instability or dysfunction which indicates a need for protective services.

Inappropriate individual behavior (mood or affect) may indicate a need for protection.

Sometimes protective services are needed to shield an adult individual from harm by others or from harming him/herself. A number of States define adult protective services in relation to abuse, neglect or exploitation by others. Older persons are particularly vulnerable. Sometimes individuals are suicidal and need to be protected from themselves. In these instances old age, great frailty, a deep depression or other emotional state may be the basis for triggering actions requiring protective service interventions.

All of these considerations appear valid criteria for providing a service which can be defined as a life-sustaining and concerned system of care to older persons unable to care for themselves.

Purposes

Another approach to surveying public protective service programs is to identify the purpose or goals for which the protective service is provided to or on behalf of adults.

States differ in stating the purpose of adult protective service. Hawaii describes the focus of these essentially casework/counselling services as enabling "involuntary" adult clients to prevent further decline in their life situations, and whenever possible to regain and maintain a maximum level of independent functioning and maximum of physical and mental health, security and safety. "Involuntary" (in this context) refers to an adult who cannot or will not apply for or request services himself or is unwilling to cope although services are deemed necessary to help him adapt to his environment or to changes in his situation.[1]

The State of Washington points out that adult protective services shall only be offered to meet the following goals:

1. To prevent or remedy neglect, abuse or exploitation
2. To prevent or reduce inappropriate institutional care
3. To secure referral or admission for institutional care.[2]

New York State identifies the goal of protective service as goal III of Title XX, "Preventing or remedying neglect, abuse or exploitation of adults unable to protect their own interest."[3]

Maine in a policy statement has identified principles which give meaning and direction to this service as follows:

"Adults are considered legally competent until ruled otherwise by a court of law and are given full protection of due process in law.

"Services are delivered regardless of client financial status, race, creed, sex, color or national origin.

"The essential factor in service delivery is protection, rather than control of the incapacitated person.

"Service must be initiated immediately in case of possible danger to the incapacitated adult."[4]

It has been said that the essence of social protective service is social therapy. Social therapy involves a therapeutic relationship using environmental supports to reach the client and restructuring the situation to compensate for the older person's deficiencies.[4]

The State of Mississippi has identified general principles of protective services in an exemplary manner. (See Appendix D).

Some States stress the method for provision of Adult Protective Services: The State of Kentucky states that "social casework is the core of a good protective service." Similarly, West Virginia states that "the very heart of protective services is casework. Without the casework relationship very little will be accomplished."[5]

Client Characteristics

A recapitulation will serve to introduce this section on client characteristics.

States provide adult protective services to individuals 18 years of age and over. By definition States identify such adults as being abused, neglected, exploited and living in settings which may contribute to loss of health and which may be unsafe. The circumstances in which they are brought to the attention of the local public social service agency may indicate their inability to cope with their environment because of an impairment in functioning, mild to severe, caused by disease or defect. Such individuals are characterized by having no one ready, willing and able to assist them responsibly (See New York State statute Section 131-1, dated March 1, 1979, as amended, Definition of Protective Service).

The State of Hawaii, in its statutes, (Uniform Probate Code—Disabled Persons) defines an "incapacitated person" as a suitable recipient of protective services. "The incapacitated person means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication or other cause (except minority)

to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person."[6]

Thirty four States indicated that adult protective services are provided to individuals without regard to income under Title XX of the Social Security Act.[6]

The State of Mississippi, writing about client characteristics, points out that a person may be an adult-at-risk if the following four criteria are present:

- the individual must be 18 years of age or older, or an emancipated minor, either by legal marriage or by judicial decree
- the element of endangerment must be present (harm or threatened with harm)
- the person must be personally vulnerable
- the person must be socially vulnerable.[7] See Appendix U for Case Examples.

The State of Kentucky identifies the "client" as follows:

One with physical or mental limitations which render him unable to act on his own behalf, to manage money and/or carry on activities of daily living, and in addition has one or more of the following characteristics:

- Behaves in such a way that is harmful to self and/or others.
- Is mentally incompetent to the degree that legal measures are or will be necessary to be invoked for his or others' protection.
- Is living in unsafe or hazardous conditions.
- Is neglected or exploited and
- Is without anyone reliable, ready, willing and/or able to act on his behalf.[8a]

The State of Utah has developed a "cumulative impairment" rating scale which takes the following factors into consideration: decision-making, activities of daily living, physical and mental health, environmental conditions and social and economic resources. This rating scale is useful in rating a client's ability to function in a social setting. (See Appendix T.[8b])

The State of Wisconsin emphasizes that it is not the services that are distinctive, but rather the people for whom the services are intended along with their circumstances and the reasons why the services are being provided.[9]

The State of Texas in setting priorities for purchase of adult services, limits such purchase to individuals involved in or subject to:

- Life endangering circumstances of physical abuse
- Life endangering circumstances of neglect—by self or others
- Circumstances of severe physical or mental exploitation
- Circumstances of physical or mental abuse which may threaten the life of the individual
- Circumstances of neglect by self or others—which may threaten the life of an individual
- Circumstances of exploitation which may result in the serious loss of an individual's property or well-being
- Other circumstances of abuse, neglect or exploitation.[10]

New York State lists 4 client characteristics and discusses them. They are (1) Incapacity, (2) in danger of harm or threatened harm, (3) has unmet essential needs, and (4) no one willing or able to assist the client "responsibly."[11a]

At this point it is important to mention one client characteristic on which there is great confusion. This characteristic, which affects the aged, is termed "senility" or chronic brain syndrome.

In considering "senility" as a characteristic of aged clients needing protection the National Institute on Aging in a brief description of senility indicates that "this is a term commonly used to describe a large number of conditions, with an equally large number of causes, many of which respond to prompt treatment.

"Serious forgetfulness, confusion and certain other changes in personality and behavior are not necessarily incurable effects of old age. Furthermore, they are frequently found in aged clients referred for protective services to service agencies. The important

thing is that a complete, careful examination of the source of the symptoms is necessary.

"The most commonly incurable forms of mental impairment in old age are multi-infarct dementia (a series of minor strokes causing widespread death of brain tissue) and Alzheimer's Disease which is characterized by changes in the nerve cells of the outer layer of the brain resulting in the death of a large number of cells.

"Some reversible conditions may mimic these disorders. A minor head injury, poor nutrition or a high fever can temporarily upset the normal activity of extremely sensitive brain cells. Also, emotional problems can be mistakenly confused with irreversible brain disease. Depression, loss of self esteem, loneliness, anxiety are common emotional problems which, if left untreated or ignored, can lead to serious problems."[11b]

Administrators should recognize the importance of understanding the manifestations of brain damage or emotional disturbance in aged persons when working with old people who are referred as needing protection.

For further information write to the Director, National Institute on Aging, NIH, DHHS, Washington, D.C.

Now, let us return to our consideration of other characteristics of the protective service client. We will be considering the following groups who have been identified in States as requiring protective intervention:

1) Voluntary and involuntary clients committed to an institution.
2) The chronically mentally ill in and out of institutions.
3) Abused persons and possible victims of domestic violence.
4) The Developmentally Disabled, Alcoholic and Drug Abusers.
5) "Street People".

New York distinguishes between the voluntary and involuntary client:

- The voluntary client is one who requests the service of the agency or is accepting of the referral for services as made by somebody else.
- The involuntary client is one who is in danger of serious harm and cannot be persuaded to see the peril and accept a viable alternative. Such clients are often referred to the agency by someone else.[11a]

Different distinctions are raised relative to the client's capacity to function normally. Mississippi discusses a client who may have behavioral and functional characteristics (bizarre or eccentric behavior, manic episodes, loss of memory, etc.) which may indicate incompetency but which is not legally established. This condition may be established as the result of medical/psychiatric evaluations as the basis for the agency's action to use legal resources. However, a skillful caseworker can help the client to eventually accept protective service, either social or legally oriented, depending upon the severity and duration of the condition.[12]

These varying state and federal criteria for identifying clients eligible for protective service lead to some general comment.

As indicated above, States include a wide range of client characteristics when answering the question, "Who is the Client?" Significantly, those characteristics which are "life endangering" or circumstances which are actually harmful or threaten harm are used by States as a basis for prioritizing those who get service. The "incapacitated person"is one who qualifies for protective service.

The distinction between the voluntary and involuntary client is very real at the point of a crisis. The voluntary client is amenable to social interventions and the involuntary client is one for whom legal intervention is too often necessary because his mental or emotional dysfunction is so serious as to make him refuse imperative care and services.

Chronically mentally ill persons are among recipients of adult protective services. The chronically mentally ill as a group have received scant attention by some State service agencies. The mental health community, which also numbers these individuals as patients, is concerned that when they are discharged from long term mental institutions there are no community resources to which they can look for services. Lack of coordination between the State mental health authorities and the State social service authorities is a major factor in the absence of

appropriate service for the chronically mentally ill adults upon discharge even where community services and resources may be reasonably available.

The chronically ill population encompasses persons of any age who suffer certain severe and persistent mental or emotional disorders that erode their functional capacities in relation to such primary aspects of daily life as personal hygiene and self care; interpersonal relationships; work; schooling and recreation, and who require prolonged institutional and non-institutional care as well as short term intensive care treatment and hospitalization. It is estimated that this group, identified by diagnosis, disability and duration of hospital stay constitute approximately 1.7 million persons nationally.*

The aged who have become mentally ill in their old age have characteristics similar to those persons identified above except for a shorter period of need for special care or shorter duration of stay in a mental institution. Their need for services is equally profound. Many now are placed in skilled nursing homes or intermediate care facilities, board and room facilities or halfway houses. Many never institutionalized but recognized as disordered or in need of protective services require the same services as elderly patients released from mental hospitals to the community. Many need services which will help them to maintain or adjust to community living; find employment; resume or take part in the normal activities of daily living; secure health related treatment, drugs and health services, secure decent housing, and obtain access to leisure time activities where they can begin to relate to others. Elderly persons released from institutions are usually in greater need than others of basic support services particularly if they have not left the institution for many years. In their transition from living in a "closed institutional environment" to "the least restricted environment" they need, initially, at least, individualized personal attention from the social caseworker to help to adjust and to regain self confidence and the ability to act independently to carry out the normal tasks of everyday living. Some may need "protective service" particularly if they cannot cope with the freedom of a community independent living environment, or are vulnerable to exploitation. (See Chapter IV—the non-medical institution as a form of protection).

There is little in State policies dealing with adult protective services to suggest that service caseworkers* dealing with clients with these impairments should be trained as well as experienced professionals in medicine, law and nursing. Throughout this monograph States are quoted as recognizing the severity of the impairments, the difficulties of dealing with client behavior which is not normal, and the judgement required by the worker (by implication if not explicitly) to know when to intervene and when not to intervene upon a client's behalf.

It is particularly important in instances when a client, particularly an older person, resists a suggested course of action to prevent harm that the service caseworker has enough diagnostic knowledge to know if the client resists because he is of sound mind and is exercising mature judgement or if he is confused in his thinking because he is senile or is mentally ill or is depressed and which has affected his judgement.** Superficial observation may suggest incompetence although the client is temporarily confused or frightened. A misreading of such evidence may result in an unnecessary placement in a mental hospital. Caseworkers obviously are not expected to make a medical or psychiatric diagnosis. They are able, if they are well trained and experienced, to make a preliminary judgement as to the client's condition which may save the client a great deal of difficulty, and if they are not they should not be assigned to protective service cases.

The case of the battered or victimized adult requires additional thought.

Victims of domestic violence are in need of

* Source: HHS Task Force. National Plan for the Chronically Mentally Ill. Chapter II Rept. Fall 1980 (Policy Cte). Definition of CMI. Fall 1980. DHHS.

**Service* caseworkers may be trained professionals or not. Social caseworkers are trained professionals with graduate levels degrees.

**These terms reflect a recognized and accepted definition of mental impairment.

protection and care. The battered child, the battered wife, the battered older family member are examples. However, it is a matter of debate whether or not older victims of domestic violence should be considered as individual adult clients in need of protective service or as family members of a disturbed family.

Victims of domestic violence are part of a family group. Others in the family need help in addition to the actual victim. The person who does the battering needs professional help. Other family members, particularly children, need care (placement, etc.). The goals for service for those individual family members who are victims of domestic violence are much different than those who need protection from harm since the integrity and continued maintenance of the family structure is central to the problem. Spinoffs can involve child care and possible child placement; marital counselling, etc. Considering the nature and ramifications of domestic violence involving older persons it might be more appropriate to deal with the problem separately from adult proection for pragmatic as well as funding reasons. States may wish to deal with abuse under *both* rubrics—i.e. domestic violence—protective services, depending upon the individual case circumstances.

Two other groups have been identified in State plans as needing protective service. One is the group of developmentally disabled, particularly the mentally retarded. Another is the group identified as alcoholics and drug abusers.

Some states such as Colorado provide for the protection of the developmentally disabled in their statutes and carry out services on their behalf. The number of disabled on Supplemental Security Income who receive services are on the rise. Throughout this monograph States and their policies and standards material are quoted in reference to the disabled. Thirty States, in their FY 1979 Comprehensive Annual Service Plans, under Title XX planned to provide protective services to the Developmentally Disabled. Eight States use the condition of developmental disability as the criteria for group eligibility.*

Six States have incorporated services to alcoholics and drug abusers as a part of their definition of adult protective services. However, alcoholism and drug abuse are problems characterized by addiction. The causes are multiple. The solution, total withdrawal. Forty-two States identify special services to alcoholics and drug abusers in their comprehensive annual service plans for FY 1979 separate from protective services for adults.* Only limited reference to alcoholics and drug abusers is made in State statutes and service manual material on Adult Protective Service.
These two groups seem to require separate programs because the character of their problems differs. Refer to NIAAA Publication—IFS #95, dated April 30, 1982 titled "The Public Inebriate".

Another group of people--those who live on the streets of every city in this country—the "street people"—have emerged as a current object of community concern. Their freedom to carry out a self-determined "life style" is challenged by authority in various guises when, during winter months in northern climes particularly, numbers of them die from exposure to the cold or its aftermath.

City governments are urged to provide suitable shelter for such individuals and many do so. However, the issue is around the imposition of requirements set by municipal authorities in the interests of public health and sanitation and the readiness and willingness of "street people" to comply with these standards if they wish to use such shelters. The dimensions of this problem nationwide are unknown. However, the matter is grave and requires serious study.**

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*US DHHS(HEW) Office of Assistant Secretary for Planning and Evaluation. Kilgore and Solman, June 15, 1979. Characteristics of State Title XX CASPS. Technical Notes #10 and 11.

**See *"Private Lives and Public Spaces"* (Harmless Adults in NYC) Community Service Society, Feb. 1981, 129 pp.

b. See - Protective Services - A.R&D project, Blenkner, Bloom and Nielsen. Social Casework, October 1971. Vol. 52 No. 8 P. 490.

5. State of Kentucky, Protective Services for Adults, Manual Material p. 22.210, 6/76

West Virginia Manual dated Sept. 1, 1979, S 29490

6. Hawaii Revised Statutes, Article V, Pt, I, Sections 560:5-101, Definitions. Also see Service Manual Chapter III, Sect. 4026.03(a)(2) Services Provided Without Regard to Income

Also Service Manual, Chapter III, S. 4026.03(2), Services Provided Without Regard to Income

7. Mississippi Service Manual, S. III, B.1, Client Characteristics

8. a. Kentucky Service Manual, P. 22-240

b. Utah DSS-DFS, UPIA - 200-250

9. Wisconsin, Service Manual "Guidelines for the Protective Service System" Part VI, p. 8, Protective Services

10. Texas Service Handbook S 5330, Protective Service Priorities

11. a. See New York State Service Bulletin #194 p. 11 and p. 26 on Client Characteristics

b. National Institute on Aging, NIH, DHHS, Washington, D.C. Age Page "Senility" U.S. GPO, 1980, 0-327-894. Also, NIA -Special Report on Aging; 1980, PHS, NIA, DHHS, NIH Pub. No. 80-2135. August 1980, p. 2

12. Mississippi Service Manual S 715.4, Client Characteristics

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Chapter III

Policies and Standards for Protective Service For Adults

This chapter moves from a consideration of how Adult Protective Services are defined, to the scope of services and consideration of State policies and standards which govern their provision.

The materials presented here are an analysis of State Policy materials on protective services for adults contributed by 40 of the 50 states in reply to a request by the Regional Office DHHS (OHDS-AOA).

The section on scope of services which precedes the section on policies and standards provides a broad canvas against which the individualized policies and standards can be sketched. It provides a means to integrate the diverse policies and standards outlined thereafter.

Introduction

A wide range of general policies and standards are applicable in the Adult Protective Services. Standards related to the intake process include those related to eligibility, confidentiality, relative responsibility and needs assessment, among others. While some of these standards are applicable to all public services, the particular applicability of these standards to protective services for adults is stressed by the States and highlighted in this monograph.

This chapter covers state policies on the intake process, the individual service plan, and complaint investigation and follow up actions. Examples of different State standards demonstrate the ways in which individual States have dealt with the same policy area. It is hoped that this approach will provide States which plan to update their own policies and standards several options from which to choose as they develop their own manual materials.

State policies and standards for Adult Protective Service have evolved over a number of years. Their stated policies reflect the States' perceptions of the nature of the clientele with whom they have to deal as well as the traditional ways in which they carry out their social services and the legal base which supports their steps to protect this group.

States providing protective services in the last half century have focused on a clientele who were mainly poor, who lived alone, many of them elderly, and with varying degrees of mental or physical impairment.

In the next half century States will probably face the need to provide protection to adults of various economic levels who constitute a higher proportion of the aged because the population of elderly is increasing. These individuals will be vulnerable to suffering from the same types of mental, emotional and physical impairments as their predecessors. However, there will be differences. These elderly will come from a wider socio-economic group. They will be better educated. These individuals will be more articulate; more conscious of their rights and less amenable to legal procedures which will deprive them of such rights.[1a]

The relationship between the State policies and standards enunciated in this monograph and actual State practice in carrying them out

is a very important one. The enunciated policies of each State represents its own performance standards. It is up to each State manager in reviewing these "guides" to determine if practice conforms to the standard set by the State and if not, what should be done about it.

A number of States have been actively updating their standards related to protective services over the past few years. Wherever possible the most current service materials have been included in this document.

Scope of Services

The overall scope of Adult Protective Services described in States' policy manuals includes non-institutional social services and also institutionalized services. Current policies in States indicate that individuals should be helped to remain in a community setting and that adult protective services should be carried out with this aim. If institutionalization is necessary, the least restrictive environment is to be utilized. Examples of manual materials on scope of services from several states follow:

The South Carolina law provides that when a county department of social service finds a senile, developmentally disabled or mentally ill person who is unable because of financial resources or physical or mental disabilities to provide for his basic needs, the agency may immediately provide care, or petition the court for a temporary order authorizing the agency to take custody and provide care until suitable permanent arrangements can be made which will ensure the protection of the health and safety of the person concerned.[1b]

South Dakota provides long term care protective services to any institutionalized adult resident of a long term care facility in the State.[2] Virginia, in addition, provides for supervision of institutionalized persons and makes reports of abusers of adults in licensed and non-licensed facilities to the licensing and enforcement authorities.

The State of Hawaii has identified a broad scope of services that are protective. It is an exemplary statement of the scope of adult protective services, (See Appendix A). It is reflective of the statement in Chapter One of this document that social casework is the core of protective service. It emphasizes the various ways in which an adult can be helped, particularly in the initial stages of protection when assessment of the client, his situation, his needs and immediate placement to protect from harm are foremost. The scope of the service is outlined clearly. Resource development and use of community resources are suggested, and other supportive social services are identified. Agency limitations on service provision are also covered in the policy. Clients' rights are emphasized and legal actions to deal with an incapacitated person are suggested.[3]

The State of Arizona identifies the following activities: intake, investigation and diagnosis, arranging for guardianship, commitment or other protective placements, assisting adults to remain in their own homes, assisting adults in securing placements in the community, providing counselling to adults at risk, their families or to surrogates; assisting in the location of medical care, legal services, other resources; recruiting, certifying, and monitoring adult foster family homes; providing ongoing supportive services in such homes; arranging transportation and arranging for the use of available shelter care for adults in need of emergency care. This is done either by direct service staff of the agency or under purchase of service contracts.[4a]

The Arizona CASP for 10/1/79, in identifying the services to be provided as part of adult protective services, reflects the State's service manual quoted above. However, a few specifics not included in the same manual are introduced in the CASP such as "provision of board and room, arranging and providing medical, psychological and psychiatric evaluations, storage of personal belongings." These activities, expanding upon the service manual, emphasize the type of social interventions necessary to provide a true protective service.[4b]

The State of Alaska includes under the topic "adults at risk," services to the elderly and handicapped, services to battered women and services to rape victims.[5]

The California manual on adult protective services states that protective services for adults constitute a service program initiated by interpretation of need in referral from third parties or by direct request for service from the client. Social work services are provided and ancillary services (medical-legal) are arranged in critical situations if the physical, emotional or intellectual well being of an adult is in jeopardy.[6]

In summary, the scope of adult protective services differs among the States from broadly to narrowly defined programs. In some States, it is based on social casework to clients who are senile, disabled, and mentally ill and emphasizes services necessary to prevent harm which the caseworker develops and carries out in an individual case plan.

In other States, the emphasis is on protection for adults who are abused, neglected, or exploited. Services can be provided by the State/County Agency in a community setting or in an institutional setting, either through direct service staff or under purchase of service contracts. Most of the States include both social interventions and legal interventions. Protection of civil rights of clients are generally emphasized.

Not only the nature but also the quality of the services will obviously differ among States. This difference is probably due to (1) the expertise of service staff who deliver the service, (2) the actual scope of the adult protective service program, (3) the size of the population universe covered, (4) the type of services provided, and (5) the amount of funds each State allots to adult protective services.

A review of the components in protective service appearing later in this document will describe more fully particular service activities and casework practices which States include in their protective service to adults.

Standards Related to the Intake Process And Client's Rights

Eligibility

Forty-six States, overall, provide Protective Services to Adults in the Title XX program. Of this number, 33 States provide Adult Protective Services (as defined in their service manual or their Comprehensive Annual Service Plans) without regard to income.* That is, there is no income test for this service. Some States, like New York, limit very specifically those service activities which may be provided to clients without regard to income under this rubric. Any other services needed in the plan of service for the individual may need to be secured from another agency or a fee may be charged for the individual service. The only individuals to receive free service are those with an income below the established income standard of the local District Office (See Appendix B, for specific details (NY CASP))[8].

The State of Hawaii clearly states that, while adult protective services may be provided to clients without regard to income, the caseworker is required to determine if there is need for such services and also to determine whether the individual lives alone, with others or in an out-of-home arrangement. The caseworker in securing this material and in her report should make it clear that the report is based upon information gathered on at least three areas: the adult, the situation and the resources available to the adult. In its procedural guidelines the State outlines in an exemplary fashion the factors which should be considered in evaluating and determining the need for protective services. The policies these procedures apply to are in Section 4111.62, Chapter III of the State's Service Manual. (See Appendix C).[9]

The State of Kansas developed the following criteria for determining eligibility for adult protective services:

(a) Any person reported in danger of being abused, neglected or exploited is

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*Ibid as reported in SSRR Report for 3d Quarter FY 1978.

eligible to receive these services.

(b) The report of alleged or suspected abuse, neglect or exploitation is a request (referral) for Social and Rehabilitation Services (Kansas Agency) to provide services on behalf of the reported person.

(c) The report may be initiated by a telephone call, letter or personal interview.

(d) The reporter of the incident may be a family member, relative, the reported adult (his/her self) or a citizen of the community who may remain anonymous if he/she wishes.

Since Kansas provides adult protective services without regard to income there is no financial eligibility requirement for this service.[10]

Some variations in eligibility policy include Connecticut which limits its adult protective services to the elderly; Maryland, which imposes fees for provision of homemaker services; Oklahoma, which limits protective services to those 70 years of age or older who are abused, neglected or exploited; New Mexico which includes alcoholism and drug addiction as handicaps which require protective service, and Washington State which includes homemaker and chore services without regard to income only if they are essential to the Adult Protective Service Plan.

In States where protective services are provided as only one component of a total adult service delivery model (Michigan) there is a tendency for protective services to be mainly crisis oriented, relying upon the other adult services for provision of preventive and follow-up support service. When so limited no eligibility criteria other than need for service is likely to be used. However, if protective service is defined to include preventive and continuing support service (cluster), the income eligibility and fee charges begin to be selectively applied to certain service components such as chore service. Thus, the way in which a State organizes its service delivery has an influence upon the way the service is defined and the eligibility requirements it imposes.

There is little reflection in State manual material about providing protective service to the middle income population who have the financial resources to pay for it. Although they may have the financial resources, they often have no access to the large public service programs because of such resources except in those States which elect to provide adult protective services to individuals "without regard to income."

In many States considerably greater numbers of the middle income population have availed themselves of protective service and will continue to do so as long as they can meet the State's test of eligibility for this service.

Some trust officers in banks, managing their clients' funds over many years, encounter changes in client characteristics and behavior common to those described in an earlier chapter of this monograph. If the client can afford it he receives first class treatment of his medical and psychiatric needs; however, if the estate is limited such individuals may not receive any treatment or help at all. It is important that administrators, and planners be aware of this group as a potential clientele for public services where they are not excluded from benefits because of their incomes.

The foregoing examples cover the principal aspects of eligibility for adult protective services in States. Eligibility determination rests upon the specific characteristics of the individual client. The situation and circumstances surrounding the client are the bases for eligibility determination plus any other financial eligibility requirement imposed by each State's laws or to meet Federal eligibility requirements for services under the Title XX service program requirements. (See 45 CFR Sect. 228).*

It is a debatable issue whether eligibility for this service which is so basic to an individual's life and liberty should not be expanded to need for service alone without regard to income. Thirty-three States practice adult protective service without regard to income. For the most part, this is a crisis service,

*Relocated in 45 CFR Chapter XIII, S.1396, August 25, 1980.

usually of intensive initial effort by direct service staff to quickly mobilize available service resources, to stabilize the situation and protect the person from immediate danger to self or from others, and to work out plans for continuing protection. This social intervention is a form of social casework service and legal interventions are called into play only when the client is uncooperative or felt to be so mentally impaired that he/she cannot be expected to manage money or carry on the normal activities of every day living, and there is no one aware of the situation prepared to act responsibly on their behalf.

Exercise of Authority in Providing Protective Services

Perhaps the most difficult and delicate aspect in the provision of protective services to adults who need it is in the use of authority by the State and its exercise in providing the service.

It has been said in this document that the unique feature of protective service is the potential for the use of legal authority. We are dealing with adults. Adults are presumed to be self determining and independent. Any efforts to interfere with the right to be self determining must be based upon the belief and the knowledge that the client's problems and his situation or circumstances or his actions are so hazardous or harmful to himself or others that it overrides the usual right to be left to make his own decisions.

States are very conscious of clients' rights. Normal social interventions, that is, the provision of services to deal with a client's problems and needs, presumes that the client's request for service or refusal to accept service springs from an individual "of sound mind and sound body", unless there is reason to doubt the individual's sanity or self control. The experience of States indicates a reluctance to intervene to upset the doctrine of self determination.

The State of New York points out that in the provision of protective services for adults the request for service may be made by someone other than the client.[12] Sometimes, even the client may express through his involuntary actions (or lack of action) a need for protection which can be interpreted by his caseworker as a request for service.

Due to the possibility of violating individual legal rights States are cautious about moving quickly, "There is a tendency", states the New York State Agency, "on the part of the public official to avoid intervention sometimes when it is clearly needed" (op cit). One State; Iowa, establishes its policy as follows: "Adult Protective Services are to be provided by securing the voluntary cooperation of the client and his family." The State's manual indicates the client's right to refuse services or to deny the need for protection may require the State to consider possible legal action to provide protection for the adult.[13] New York indicates the use of "gentle persuasion" by the caseworker to help the client move to a voluntary status and accept a "plan for care," recognizing that this may not always work.

Mississippi has this to say about social intervention: "Recognizing that the client's rights be carefully guarded, when dealing with a client who it is determined can no longer look after his own interests and does not have family or friend who can or will do so for him, it becomes the responsibility of the Department of Public Welfare to try to protect the client against himself and against the actions of others that are not in the client's best interests. The Department will first seek out responsible relatives or other appropriate persons who could act as surrogates for the client because the Department is to act for the client only if he has no guardian or relative or other appropriate person able, willing and available to assume the kind and degree of protection required under the circumstances." (See Appendix D for an example of the framework of adult protective services.)[14]

Alaska, whose adult protective service policy is in the development stage at this writing, states that under adult protective services policy a social service worker shall provide this service only when the client voluntarily agrees to accept services. The Department does not have statutory authority

to intervene to serve adults in a protective capacity.[15]

In New Mexico, the State agency has a responsibility to receive and evaluate all reports of the neglect, abuse or exploitation of adults. Staff must respond to such reports as soon as possible. The social worker's authority to intervene in cases involving an adult living in an institution derives from State law authorizing the agency to administer social services for adults.[16]

In North Carolina, the statute defines the word "emergency" as follows. The word "emergency" refers to a situation where (i) the disabled adult is in substantial danger of death or irreparable harm if protective services are not provided immediately, (ii) the disabled adult is unable to consent to services, (iii) no responsible, able, or willing caretaker is available to consent to emergency services, and (iv) there is sufficient time to utilize procedures provided in S.S. 108-97 (petition to court for protective services, i.e., legal intervention). [17]

In summary, States approach the question of intervention in the life of an adult very carefully. The adult or his surrogate is expected voluntarily to request service or recognize a need for help. In the situation where an adult may not recognize or refuse to admit that he or she is not in full control of his/her facilities, then States will move, using persuasion and other means to induce the client to voluntarily accept agency assistance. When it is evident that there is no one ready, willing and able to act on the client's behalf, some States will assume this reponsibility, others will not. An emergency situation may force the State/local agency to act to protect adults from harm usually through legal intervention.

The issue of cautious investigation of the problem in adult protective services versus the need to act quickly places the burden squarely upon the worker. This is a judgement call. The need for skilled staff to carry out this service is obvious. The use of professional authority by a professional social worker in such cases is required.*

Relative's Responsibility for the Client

The responsibility of relatives for the personal welfare and for financing the cost of care of aged relatives remains an issue of public policy.

It is evident that relatives of seriously mentally/physically impaired adults are expected by a few States to assume responsibility for protective care of their relative.

Mississippi states that whenever possible, children, relatives or interested persons of older adults who are in need of protective services should be notified immediately in an effort to enlist their assistance in helping the abused, neglected and/or exploited adult. Notification of interested parties is a must where commitment proceedings are involved. In most cases, children, relatives or interested persons will consider it their right and responsibility to assist the adult rather than utilize the Department of Public Welfare.[18]

The State of Alabama indicates that where the client is incapacitated, relatives and other interested persons should be allowed and encouraged to assume responsibility to the extent that they are able.[19]

However, most States do not refer to the subject in their service manuals. An attitude has developed in recent years that adult children, usually with families of their own living in urban settings, may be unready and even unwilling to provide a measure of protection to their aged parents. Such relatives have limited means. They may conceive their primary duty is to care for their own children rather than to care for their older parents. Relative responsibility for financial assistance in support of older adults has ceased to be a Federal requirement. The emphasis today is on parental support for minor children in instances of desertion or child support. Payments are required as the result of divorce or as a result of paternity suits in a number of States. Furthermore,

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*See *Guardianship and Protective Services for Older People*. The National Council on Aging. NCOA Press 1963 which discusses this matter fully on p 117.

many spouses or relatives are not competent themselves to assume the multiple responsibilities for attention, care and supervision of older and impaired adults.

The increasing costs of medical care for older persons and reduced Federal responsibility may force a relative to assume a greater share in these costs.

Confidentiality

It is illegal to disclose confidential information about clients except under certain prescribed circumstances:

Most States have a long history related to protections against disclosure of information about clients to others without their consent. The development of automatic data processing and the use of computers has made it extremely important for the State to protect the client's privacy by refusing to disclose information to others without his/her knowledge and consent. Conversely the problem of withholding information about clients who are severely mentally impaired to relatives and other authorized persons who have a need to know is a serious one. A number of unfortunate situations, including murder of a spouse, have arisen when information about a client was withheld by the Agency from those entitled to know. Such entitlement may be based on authorized legal function (police) a spouse (a legal relationship), etc. It is the responsibility of the agency to determine the extent to which disclosure of information on a client to others without his/her consent is justified and upon what grounds. Examples of State regulations follow.

The State of Nebraska clearly expresses its policy on disclosure of personal information about a client which comes to the attention of the social service staff in the course of their protective service activity. Such information is subject to the State's confidentiality regulations Part IX, Sections 8100, 8110, 8120, 8130 and 8140. Furthermore, the local service unit is prohibited from releasing information concerning the client to another agency or individual without the consent of the client.[20] See also Nebraska Public Welfare Manual Section 1395.01—Disclosure of information.

A similar policy is in effect in South Dakota in relation to the institutionalized Long Term Care (LTC) client. The identity of any complainant (of abuse, neglect or exploitation) or resident of a long term care facility shall not be disclosed by the LTC specialist unless such complainant or resident or his legal representative consents in writing to such disclosure or such disclosure is required by a court order.[21]

Alaska makes it clear that all reports of known or suspected abuse and neglect and exploitation and all records generated as the result of such reports which identify individuals by name and address shall be kept confidential. Access to reports shall be limited to authorized staff of the Division of Social Services in the performance of their official functions.[22]

Arizona, discussing disclosure of information on a client clearly states that no medical diagnostic information unknown to the client is discussed with him without consent of his physician, legal guardian and/or caretaker relative.[23]

Assessment of Client Need for Protective Services

The next two sections, "Needs Assessment" and "Criteria of Need" are representative of States' efforts to develop more precise instruments for determining a need for protection by adults referred to the agency.

They attempt to answer such questions as: Is the person in immediate danger? Is emergency intervention needed? "Why does he/she need protection? "What are the principal factors in determining a need for protection? What distinguishes a "need for protection" from a "need for in-home services"? What are the elements of a good needs assessment?

The next following section, protective needs assessment, deals with the vital requirement for this approach—the elements of good needs assessment and principal components of a good approach to identifying a need for protection.

Adults referred to the public protective service agency exhibit certain characteristics

which trigger a recognition that they need protection. Some factors are obvious: victim of abuse by another, disordered thinking, memory loss, impaired judgement. Other characteristics are not so obvious and include mental depression, suicidal tendencies, suppressed rage, devious and manipulative behavior.

As these sections are reviewed it is worth considering that this implies that agency direct service staff providing protective services must be knowledgeable enough to use a needs assessment schedule and criteria, and skillful enough to apply the knowledge in service to their clientele. States need to train staff, if they have not already done so, to recognize unusual behavior and to deal with it in individual plans for service. Also, because of the many mental and physical impairments that may necessitate the provision of protective services activities, State Administrators and planners should be prepared to incorporate in planning and programming the use of the multi-disciplinary approach for determining client need in the State's protective service cases.

Protective Needs Assessment

The State of New Hampshire points out that whenever possible, the social worker and the referred adult assess the adult's situation and together determine whether or not protective services are necessary and which services will be provided. The assessment process developed by the State is an exemplary one. (See Appendix E.)[24]

The State of Kentucky has identified very specific criteria service workers can use for assessing possible abuse, neglect or exploitation to clients. Descriptions of physical abuse, emotional trauma, and neglect and exploitation are provided which give the staff the essential characteristics and restrictions of the terminology used. Other criteria include a definition of spouse beatings.[25]

The State of Nebraska refers to the development of a needs assessment as part of a service plan. This is carried out by a service worker in interviews with the client and with other sources. See Appendix K for details of all the determining factors (caretakers, relatives, law enforcement, etc.) leading up to service planning and including needs assessment.[26]

Alaska, California and Florida also indicate that an initial assessment to determine whether or not this is an adult protective case is part of their policy.[27]

The State of Oklahoma, in its statute dealing with protective services for the elderly, indicates that in order to make the finding that a need exists for continued service (after 1st 24 hour emergency), the court shall direct that a comprehensive evaluation of the elderly person alleged to be in need of continual services be conducted by the geriatric evaluation service. This will include a medical, psychological, psychiatric and social evaluation and review.[28] New York has a similar practice.

Both of these sets of criteria are exemplary indices of the importance which some States put on general assessment and criteria of need which are very significant in ultimately helping the individual. Thus, the services delivered as part of the protective goal will tend to be more directly focussed on the particular individual as a human being unique in himself who needs protection for reasons which apply only to himself and to no one else. In this way, inadequate or inappropriate actions which may not be effective are avoided.

The State of Rhode Island, in keeping with their well developed theoretical framework for assessment of need, has specified detailed criteria for individual behavioral signs of eligibility for protective services. Their guides follow:

Some individuals, despite the absence of any impairment, fail to function adequately for reasons unrelated to their decision making capacity. While in either instance intensive casework service may be appropriate, protective service is required only when they converge and a client is neither functioning adequately nor is capable of

making decisions to prevent exploitation, abuse or neglect.

Some of the specific behavior which may indicate a need for protective services are where the client:

- Is so forgetful or otherwise mentally disorganized as to neglect activities of daily living;
- Neglects his personal hygiene and/or refuses to eat, and/or is ill and refuses to receive needed medical care;
- Is inappropriately clothed, i.e., not dressed for protection against extreme weather conditions or wears winter clothing in extreme heat;
- Is oblivious of or refuses to correct or leave unsanitary or hazardous living conditions, or creates situations hazardous to himself or others;
- Gives money or possessions away; spends or hoards money and goes without essentials; constantly loses checks or money, keys, food stamps; does not open mail;
- Is unaware or too feeble to protect self against abuse, neglect or exploitation (financial, physical or sexual);
- Isolates self, locks or barricades self in own apartment or home;
- Over or under medicates or attempts suicide or otherwise causes self injury; acts bizarrely, hallucinates or is disoriented as to person, time and place; wanders off;
- Causes injury to others or repeatedly causes disturbances in the community.

Factors for decision: The Chart below illustrates the basic dimensions of the criteria for determining if a client is appropriate for adult protective services:

no danger* plus no incapacity	no danger* plus incapacity
danger* plus no incapacity	danger** plus incapacity

*Not sufficent for protective service.
**Indicates needs for protective services.[31b]

Payment of Costs and Fees for Protective Services

Although some States provide this service without any charge, a number of other States include in their service manuals references to payment of costs of protective services.

Connecticut indicates that if the elderly adult is a recipient of State supplemental program (SSI) or a Title XIX recipient there is no charge for providing adult protective services. However, the service worker apparently must determine if the elderly person can pay. If he is able to afford it then payment is expected. If service is provided in an emergency, payment can be deferred until the crisis is over.[32]

Similarly, North Carolina in its statutes—"Article 4A—Protection of the Abused, Neglected or Exploited Disabled Adult Act"—makes it clear that if an adult is capable of paying for the essential services then he shall make reimbursement for the costs of providing the needed essential services. If it is determined (apparently by the worker) that the adult cannot pay, then the service shall be provided at no cost to the recipient of the service.[33]

In an Oklahoma statute, the costs of providing protective services to an adult shall be borne by the Department unless the elderly person agrees to pay for them or the court authorizes the Department to receive reasonable reimbursement from the person's assets after a finding that the person is financially able to make such payment.[34]

A number of States in their statutes or service manuals indicate that costs associated with adult protective services, particularly the cost of legal interventions, should be paid out of the estate of the ward/conservatee. If the client is indigent or otherwise unable to pay, the costs are borne by public funds—county or State.

One State, South Carolina, which involves nursing home costs as a part of their protective service package, provides for payment of nursing home bills on the part of

whoever signs the patient into the institution. The worker, in this State, lacks the legal authority to sign for and bind the Department in contractual proceedings. For purchase of care this State has established an emergency adult protective service fund in its system to assist counties in providing emergency protective services to eligible senile or developmentally disabled adults. The fund is limited to cases where the client is without resources, or the court has ordered the agency to provide protective services or the individual is in dire need and a court order is an unnecessary infringement on personal liberty.[35]

Policy on Social Intervention—Opportunities and Limitations

The State of Washington bases its social intervention activities upon circumstances of crisis proportions or chronic situations in the lives of clients which may be degenerating or subject to an acute flareup of illness. The goal of this intervention is to help the client to resolve the crisis or halt deterioration of the situation. The circumstances include neglect of the client's need for food, clothing or shelter by a relative, spouse or custodian; abuse of the client by same; exploitation of the client's reserve by others; or loss of protection from unsafe or unsanitary conditions.[36]

The State of New York in its protective service system for adults aims at the prevention, reduction or elimination of neglect, exploitation or crisis breakdown through the provision of services appropriate to the individual's needs which will strengthen his capacity to function in everyday life and maximize his ability for self direction.[37]

The State of Louisiana points out that when an individual harmed or threatened with harm is unwilling to accept service, the worker must utilize casework skills in an effort to assist the individual to understand the benefits of social service in his situation and to accept help. However, the State has rules, identical to Mississippi (below) which restrict caseworker action when the client absolutely refuses to accept service after the worker has attempted by persuasion and consultation to make him change his mind.[38, 40]

The State of Mississippi in its service manual lists certain restrictions on the caseworker's action in an adult protective service situation particularly when the client refuses service. The worker shall not take any of the following actions:

(1) Enter the individual's home against his will and without his permission.

(2) Remain in the home after the client, a member of the family or someone entitled to make the request has asked the worker to leave the premises.

(3) Provide social services when the individual has stated that he does not want services.

(4) Look through personal possessions of the client without his permission.

(5) Remove the individual client, against his will, from his or her living quarters to another living arrangement.

(6) Take direct action to commit an individual to a mental institution.

(7) Arrange for an individual's admission to a hospital or nursing home against his will.

(8) Manage an individual's money or property.

(9) Direct the individual's action against his will or without his permission

(10) Take direct action in judicial commitments, coroner's commitments or emergency commitments.

(11) Discuss case situations which violate confidentiality.[39]

This exemplifies respect for the client's rights to carry out his/her life with as little interference as possible from others. The tension between individual responsibility on the one hand, and the social responsibility to protect the individual on the other (the State as "Parens Patriae") is an ongoing, ever-present component of protective services. "Due Process" alleviates this tension. See Chapter V for further discussion of this issue.

The State of Arizona instructs staff members to report all felonies to law enforcement officials which come to their attention in carrying out their duties.[41]

To summarize, States determine when it is appropriate to intervene and when not to intervene in a client's situation. Some States are anxious that social intervention techniques can be utilized to persuade clients to take a recommended course of action—up to a point! Note the explicit limitations on case managers which reflects respect for clients' rights to privacy which some States outline in their policy manuals. The State of Louisiana admirably suggests the use of casework skills as an effective means to deal with clients who because of characteristic deficits in mental functioning or under emotional stress (fright or anxiety) may be unwilling to make a decision beneficial to them. This is one effective means of decreasing suffering and obtaining movement in a case situation where inaction may be fatal.

Policies on Placement—Protective Placement—Standards

States vary in dealing with the question of placement for adults needing protection. Note the distinction between placement for socially appropriate purposes and legal protective placement: the voluntary nature of social placement is implicit but the adult's consent must be obtained. In the Section on legal protective placement (below) there is mentioned a court-imposed placement without the client's consent.—that is, "custody" as a court-ordered status.

The State of Arizona, for example, provides that the adult service worker may help the adult find a local resource which can provide overnight or short term care. Placement with the adult's consent may be in a shelter care facility or a receiving home.[42] Similarly, South Carolina, in an appendix to its manual on adult services, which combines their statute and service manual (Appendix A) indicates that voluntary placement may be made to such facilities as nursing homes, boarding homes, personal medical institutions, foster care services or to other appropriate facilities.[43]

New Mexico like Arizona and South Carolina authorities considers placement that is socially oriented and provides a protective service, and refers to the possibility of a more legally oriented placement by pointing out in its manual that if institutionalization is appropriate, the worker shall refer the client to mental health agencies or other suitable facilities. The worker may counsel the client and his/her relatives to prepare for the move. The Mental Health system would be responsible for the placement, voluntary or involuntary, under State Mental Health law. Such facilities would include skilled nursing homes, and intermediate care facilities, adult residential shelter care, or boarding homes. The provision of such placement is outlined in the State's manual.[44]

The West Virginia Legislature authorizes the placement of an adult who a law enforcement officer felt, from personal observation, would suffer immediate and irreparable injury or death if not immediately placed in a health facility, and who was incapable of giving consent because of the situation. It was deemed appropriate that the peace officer making such an observation transport the adult person to an appropriate medical facility and advise the appropriate agency or person. However, this action is not yet a part of the State law.[45]

The State of Arkansas in its statute dealing with protective services (Act 166 of 1977) provides for temporary protective custody. The statute provides that the State Department of Social and Rehabilitative Services Representative, a police officer, a law enforcement official, or a designated employee of a city or county department or office of social service may take a developmentally disabled adult or an adult suffering from the infirmities of aging or other like incapacities, into temporary protective custody. Also, any person in charge of a hospital or similar institution or any physician treating any such adult may keep such adult in his custody, whether or not medical treatment is required. If the circumstances or

condition of the adult is such that continuing at his place of residence or in the care or custody of a parent, parents, guardian, or other person responsible for the adult's care, presents imminent danger to such adult's life or health, that statute adds the caveat: "provided, however, that such temporary protective custody shall not exceed seventy two (72) hours and the probate court and the department shall be notified immediately upon taking such adult into temporary protective custody, in order that adult protective proceedings may be initiated."[46]

The State of Hawaii has dealt extensively with institutional placement also.[47]

In practice it is usual for State/local authorities when they consider the adult to be in certain defined circumstances to utilize legally authorized protective placement procedures. We have illustrated protective placements which do not always involve resort to legal intervention. Current philosophy insists on placement in the "least restrictive environment," and only where the welfare of the client is at stake.*

It is possible with skilled casework to obtain the client's consent; or if he is so incapable of consent that, as in West Virginia, a police officer must arrange for temporary emergency protective placement in a hospital. If the client does not consent or the danger of harm is possible then resort to legal intervention is a sound practice.

Such work requires a protective service worker who is professionally trained, experienced and knowledgeable about the nature and characteristics of protective service law and gerontological social casework practice. Such a person can save the agency time and money by making the soundest recommendations for protective care and by acting to protect the frightened individual's sense of what decisions and choices he can make or go along with, and to offer reassurance. Workers who are inexperienced are less likely to use social instead of legal protective measures because of the difficulty and complexity of establishing a supportive relationship with impaired clients, and in securing a range of services from different providers and coordinating their use. Such workers prefer to use institutional placements, resorting to the court to deal with the situation. States should consider the value of investing in the careful preparation of a cadre of professionally trained staff in the next two decades as the proportion of the aged rise in the total population, increasing the likelihood of an increase in protective service cases.

The examples cited demonstrate that some States prefer to utilize socially oriented placements—foster care; own home, with relatives, friends; bolstered by supportive social services such as homemaker service, home delivered meals, etc.—before moving to temporary protective custody, as in Arkansas, and also before institutionalization by others as in New Mexico.

Money Management and Protective Payments

States differ in their approach to protective oversight of an impaired client's resources. A review of typical money management problems may be helpful in considering how various states attempt to deal with them in socially interventive or administrative ways.

The question of dealing with a protective service client who is incapable of handling his check, either in an independent living situation or in an institutionalized setting, has been a public service agency responsibility for many years.

There are a number of ways in which a client may lose his funds. They may be stolen, misappropriated or embezzled by others or misplaced or lost or hidden away and forgotten by the client himself. He may spend the money in bizarre ways, or fail to buy necessities in favor of squirreling money away.

It is not uncommon, particularly in poor neighborhoods, for the client to be "mugged" on the day the social security check is delivered. The client's post office box may be rifled. These are criminal offenses. The Social Security District Office usually has to issue another check for the client who has been robbed of his monthly SSI check.

A more subtle means of exploitation is for

*Refer to Chapter IV - Social Interventions - Section on "Social Care", in which placement for socially oriented purposes is discussed.

the local entrepreneur to take a portion of the client's check as a fee for "cashing" it. Also the individual may be exploited by so-called "friends" who force him to stand several rounds of drinks with the "boys." Otherwise he is "isolated" and "ostracised."

Clients who hide their assistance payments then forget where they put them are not uncommon. The local county agency caseworker visiting the client's home can usually help the client find his/her check.

The embezzlement of a ward's funds by guardians is not uncommon. This is a serious problem for the client, the court, and the guardian when he/she is caught, for this is a criminal offense.

Misappropriation of client funds by the public agency or the public or private institution responsible for such clients sometimes occurs. This may take the form of withholding a part of the client's funds to be used later and thus protect his assets. However, loose bookkeeping may result in these funds being allocated elsewhere and thus the client loses his money. Better accounting methods and use of effective and efficient data processing systems as well as regular audits of clients' and patients' funds will correct these abuses.*

Public Social Service Agencies carrying out Adult Protective Services in the climate of the '80's will probably face the need to take out liability insurance to protect themselves against charges of mismanagement and misappropriation of clients' funds if they cannot fully account for them. Alternatively, a public social policy is needed which will charge the Public Service Agency with the duty to so manage their client's funds that they are not lost or misappropriated. Such a policy may well be established by the legislature under community pressure by advocates of clients' rights.

It would be sensible for States which have not already done so to establish in their policy issuances suitable standards, programmatic as well as fiscal (which may be in place already), to ensure protection of client's funds.

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*See Senate Special Committee on Aging Report 95–453, p. 42, re protection of patients' funds and Final Regulations: Medicare and Medicaid programs - Protection of Patient's Funds - 42 CFR Parts 405, 442, and 447 - Federal Register/Vol. 45, No. 144/Thursday July 24, 1980.

The states in their service manuals reflect these considerations in a variety of ways.

South Carolina, in its service manual, points out that almost without exception an individual in need of protection will need help in the handling of his income and resources. Preferably a relative or close friend would help with cashing checks, making purchases or arranging for services. If a client is living in a boarding home or nursing home situation the worker should arrange for a responsible person, preferably a relative, to handle necessary transactions and account for the client's monthly purse money.[48]

Washington State indicates in its service manual that when a service worker establishes that the client's misuse of funds is threatening his/her well being, this fact should be documented in the service record and a request made to the community service office Regional Administrator to authorize protective payments. The State limits protective payments in its plan to managing allowances for the cost of chore service, restaurant needs or general assistance grants.[49]

New York and other States resort to the use of the representative payee for social service clients who are in receipt of a Social Security payment (SSI-OASDI, etc.). A representative payee is a person approved by the Social Security Administration to receive benefits on behalf of an eligible person when there is positive legal, medical or other acceptable evidence from social agencies, professional and lay persons presented which establishes that the beneficiary is unable to manage his assets or protect his interests by reason of physical or mental impairment. As in the South Carolina manual, these states suggest every effort should be made to secure a reliable person to act in this capacity. In States such as New York, the District Commissioner of Social Service may be named the representative payee. The case manager, acting as agent, will be responsible for determining with the recipient, when possible, which bills the recipient should forward to the worker for payment and how

the money will be allocated. The role of the representative payee for clients in different States is described. This is exemplary. See Appendix I.[50]

Connecticut and Maryland have stated in their service manuals that when a social worker makes an evaluation based on his/her judgment that the individual either lacks the capacity to manage his money judiciously or lacks capacity to consent to someone acting to manage his money (representative payee), the social worker is expected by the agency to exhaust all alternatives to secure a protective payment and must then consider court action.[51] The willingness to resort to the use of legal intervention to protect adults reinforces the uniqueness of protective services.

Policies Related to the Individual Service Plan and Methods of Service

Individual Service Plan

An individual service plan for adults needing protection is very difficult to develop. Usually such persons are referred in crisis situations. Each case is different. However, there are a few common guiding principles which are useful to follow for every protective service case:

1. If there is danger of immediate harm to the client, then he/she must be removed from the harmful situation as quickly as possible or the situation must be changed.
2. As a means of stabilizing the case and to gain time to adequately plan for services, temporary shelter may be indicated. The caseworker may assist the client to relocate.
3. The principal purpose is to protect the client. However time must be taken to identify pertinent background information about the client as a basis for solution. This may require a medical diagnosis, social history and a psychiatric evaluation. Thus, temporary shelter placement, in addition to allowing time for professional scrutiny of the case, provides an opportunity to marshal community services and resources to meet the client's need for service and care. Also the family, friends and caretakers can be contacted in this period as a basis for support services to the client.
4. If, on the basis of a professional evaluation, there is a possibility that legal resources may be needed, there is time to alert the appropriate law enforcement authorities and the Court so that necessary legal procedures can be instituted on the client's behalf.
5. Arrangements for a satisfactory solution to the need for protective services should be initiated only when all the facts are available and those responsible for the client (family, etc.) and other appropriate authorities can be involved in decisions for or with the client. The client, if capable, must always be involved in each step.
6. In principle, the doctrine of the least restrictive alternative should prevail.

Individual Service Plan—State Policy Examples

Iowa states as policy that the service worker shall develop a casework plan for each adult referred in which the investigation indicates a substantiated protective concern.[60]

The State of Arizona provides that the adult (needing protective services) shall be assisted in identifying and understanding his needs and will be involved in case planning whenever capable.[61]

Texas makes it clear that in developing a service plan for its protective service clients, that the principle of the "least restrictive alternative" must be followed. The plan must call for services that impose the least possible restrictions on the person's freedom, mobility, and civil liberties. The worker is expected to obtain the facts, evaluate or assess the situation, develop a service plan and implement the goals planned for the client.[62]

The State of Alaska lists the elements of case planning. The material is a good example of process and is outline in Appendix J.[63]

The State of Nebraska outlines the components of service planning for adults. It is worth reviewing since it is specific to adults in need of protection. See Appendix K.[64]

Caseload Standards

A case illustration of standard setting for caseloads can serve to introduce consideration of its importance.

The State of Louisiana points out that an adult service worker responsible for protective service cases should have a caseload size which will assure the worker will be actively providing services each month to no more than 35 individuals. Since the standard for establishing the caseload is based upon frequency of service delivery, the number of actual active protective service cases assigned to a worker and recommended by the State of Louisiana should be at any one time no less than 35 but could be as many as 150 or more individuals if all do not require service over the month.[65]

It is noteworthy that a State agency refers in its policy documents dealing with adult protective service to the need for specific caseload standards for carrying out this particular service activity. Adult Protective Services provided to seriously impaired clients of any description is an intensive commitment of worker time and expertise, most intensively in crisis situations of short duration, although the aftermath may require equally strenuous efforts to achieve a permanent solution in the case. All States seriously considering the provision of this service should adopt a similar policy, not only for the sake of the client but also on behalf of the casework staff. Caseworker "burn out" is a common phenomenon because of the time consuming and emotionally draining nature of this service.*

It is therefore appropriate that each State establish a realistic caseload standard for adult protective service cases after suitable experience in carrying out this service.

*See also the section on Nature and Type of Social Interventions (Chapter IV) on caseworker "burn out" and need for a caseload standard.

Case Management in Protective Service for Adults

The State of Kansas clearly, explicitly and in an exemplary fashion describes the case management function and its components. (See Appendix L.) Intake, eligibility determination, consideration of service delivery, social service plan, assessment of clients' financial and personal need for service, monitoring/evaluating purchased service, are the principal tasks outlined.[66]

As was discussed previously New York State identifies two types of Adult Protective Service—social protective services and legal protective services, with case management/social case work as the core of an effective protective service program. The State points out that local protective service staff must have knowledge and skill to assess and evaluate, to make decisions, to enlist other medical, psychiatric and legal help as necessary in evaluation and treatment, and to coordinate those services which should alleviate the individual's plight.[67]

The State of Washington points out that the service workers in community service offices, (local districts—counterparts) are responsible for case management and service planning for all adult protective service cases. This has implications for adult protective services purchased from private or public agencies by the local counterpart, if any. This is particularly significant where recourse to the use of legal interventions becomes necessary. The legal basis for providing protection to adults rests with the State. The use of legal authority belongs to the State. The issue is twofold—how can the State control the use of legal authority by a subcontractor, and how can the client's rights be protected? The role of the case manager is the key.[68]

The State of Alaska, (See Appendix M) also clearly expresses the case management function under several circumstances: (1) when other resources are being used; (2) when casework help is being provided; and, (3) when homemaker support is being provided.[69]

Whereas the States quoted accept the case management concept in principle, none defines the term. New York State equates case management with social casework. The State of Alabama emphasizes a community organization function for case management. The State of Kansas identifies it as an intake process and eligibility assessment function. It would appear that, for many States, case management combines the individual casework function involving development of a case plan with the client and follow-up within the agency's own service program, and the community organization function practiced by the agency staff which facilitate client access to services in other human services systems by planning, advocacy, negotiation, bartering, or through joint agreement with other agencies or facilities.

Case management, by whatever name, is the core of adult protective service. The nature of the service involves social, medical and legal components used cooperatively, consecutively or concurrently to achieve the goals of the case plan. Thus case planning and case management fit together as the warp and woof of the protective blanket which we use to help the client.

The contact with other professions—medicine and law—calls for knowledge of the other professions and how to approach them to secure cooperation. It involves enough knowledge of the professional ethics, and also skill in coordinating on the part of the case manager/social worker so that the physician, the nurse, the lawyer, the psychiatrist, the medical society, the VNA, the Bar Association will not feel that their "turf" is being invaded but that their expertise is being sought, for a common client.

The client in a protective service situation usually needs a great deal of help with his/her problem but may not recognize that such helps are needed and may refuse to accept it.

Management of the client—and that is what a case manager is supposed to do—must be subtle, skillful, ethical and it is hoped, successful. The use of professional consultants by the case manager to deal with the medical and legal aspects is encouraged. Social Worker Consultants can and have served in case conferences on difficult cases where their insights are particularly valuable in assisting agency staff to make decisions around social diagnosis, placement, service and care questions. It is part of the case management function to seek out and use others in this consultant role as well as to refer cases for professional diagnosis and treatment.

Use of Alternative Community Resources

A variety of ingenious methods of coordinating community-wide services for aged, disabled and minorities is used by the States.

The State of Washington Department of Social Services clearly outlines the importance of interface with other agencies in its service manual. Two particular groups are identified as eligible for State protective services in addition to the impaired aged: the developmentally disabled and Indians.

The local community service office service worker is expected to collaborate with the local counterpart of the State Division of Developmental Disability (DDD) in giving protective services to the developmentally disabled adult. Complaints from DDD are referred in the community service office to the adult protective service unit, which has responsibility for the investigation. The results of the investigation as it concerns mentally retarded adults will be the basis for development of and carrying out the service plan to alleviate any problem of abuse, neglect or exploitation and for referring the report on action taken to the central registry.

Homemaker and chore services to provide household help and to help a developmentally disabled (or Indian) client adjust to a physical change such as blindness or stroke; volunteer services for transportation; financial services as needed, and the use of nursing care consultants complete the list of component services which can be utilized to deal with the problem.[70]

For Indian clients the Arizona Department service worker shall confer and coordinate with all existing available Indian community resources before exploring the Department's non-Indian resources.

For all clients the service worker may also

confer or coordinate with:

1. Federal agencies (i.e., Social Security Administration, or Veteran's Administration.)
2. Mental health clinics regarding mental health services and/or institutional commitment.
3. County health services for home nursing service.
4. Area Agency on Aging for meal service or nutrition counselling.
5. Legal services to establish guardianship or for help on other legal problems regarding the protection of the client and/or his resources, such as landlord-tenant problems, foreclosure, etc.
6. Senior citizen centers for personal social experiences.
7. Other community resources for service essential to the protective service plan, such as resumption of utilities, daily telephone check-in, etc.

The State of Arizona points out that the adult protective service worker shall visit or otherwise contact all persons who will, or might be willing to, help the adult achieve his planned goal.[71]

The State of Texas indicates that staff should make full use of community resources. The agency points out that while protective services may be delivered by the Department of Human Resources staff, or purchased through a contract agency, existing resources such as district or county attorneys, legal aid societies, and local referral services should be used by the worker when possible.[72]

The State of California provides that the county welfare department shall establish an effective system of protective services for adults which includes referral procedures and development of remedial resources through liaison with the courts, law enforcement agencies, Social Security Administration district offices and other public and private agencies.[73]

The use of alternative resources by public social service agencies is a common practice. It is not possible for a human service system to be so self-contained that it has service resources to meet every service need. In rural settings the principal and sometimes only service resource is the public social service agency. In urban settings other resources may be present but not always readily available. Thus States need to be cognizant of specific community service resources which can be actually available when needed, and how they can arrange to secure and use them. They should also be aware of unmet service needs.

The Utilization of Volunteers in Social Interventions

States, in their program materials, rarely refer to the use of volunteers in providing protective services to adults. However, the use by the agency of volunteers, that is, individuals who provide unpaid service, should be considered. They can be used to assist the caseworker as part of a team effort. Non-profit agency services have successfully utilized volunteers in their service programs for years at a significant cost savings to the agency and with important benefit to clients.

There are certain criteria which States wishing to use volunteers in adult protective service programs should follow:

1. A State must be prepared to establish and adequately staff a volunteer program activity at State and local levels and fund it accordingly.
2. Establishing a volunteer program at the local level implies carrying out the following functions:
   (a) recruitment
   (b) orientation
   (c) training
   (d) general and direct supervision and evaluation
   (e) reward
   (f) removal
   (g) providing fiscal supports
3. Recruitment of volunteers is not a one-time affair. Recruitment must be continuous to be successful.
4. A volunteer in this program must be accepted as the equivalent of a permanent staff member in terms of meeting personnel and administrative (i.e. confidentiality) standards. Individuals willing to serve as

volunteers must be readily prepared to accept such standards.

5. The agency must expose volunteers to training including familiarization with agency policy materials since they will be participating in this service program and will be carrying out individually assigned functions under it.

6. Volunteers must be provided the same protections as agency staff in terms of liability and malpractice insurance and bonding.

7. Volunteers in this program must not be discriminated against by other agency staff in carrying out legitimate supervised functions under the adult protective services program.

Volunteers can be utilized as case and administrative aides in this program as well as to carry out office functions and other tasks connected with the provision of adult protective services.

There are a number of activities to which volunteers can be assigned under the overall supervision of the caseworker/team manager. Volunteers can:

(a) Accompany clients to physician's offices or to clinics, hospitals or other health facilities for purpose of medical diagnosis, observation, treatment or care.

(b) Assist in arrangements to secure temporary or emergency shelter for clients in crisis situations and accompany clients to the shelter.

(c) Participate in arrangements for clients to leave long term care institutional settings. They would accompany the client leaving an institution and enter him/her at a designated community-based living arrangement.

(d) Arrange for homemaker and/or chore service schedules to maintain a client's home as part of a protective service case plan.

(e) Provide transportation of clients from home to service facilities (i.e., Adult Day Care setting).

(f) Accompany client to Social Security District Office to help him/her apply for financial assistance.

(g) Carry out preliminary identification of a responsible person who could be prepared to serve as a representative payee, and report back to the agency on results of the inquiry.

(h) Arrange to accompany and transport the client to attend a court hearing on client's commitment to an institution.

(i) Develop community service resources, hitherto untapped, which can be used by the clients as part of the service plan.

(j) Serve in a support role in many aspects of the protective service program. For example he could, under appropriate direction, carry out necessary office procedures related to the program such as: analysing and organizing statistical materials, producing reports based on such analysis, carrying out office procedures related to case controls and case plans, maintaining case files.

(k) Provide "follow-up" friendly visits to maintain and support independent alternate living arrangements and prevent loneliness and deterioration.

(l) Serve as representative payees or guardians for public welfare clients.*

Supervising volunteers is a major administrative function which may be undertaken by the caseworker as head of the Adult Protective Service team. Such supervision would include on-the-job direction including assignments of function and direction of the volunteer in carrying them out. It also involves exposing the volunteers to the nature and scope of the agency's protective service programs. This means also, exposing the volunteer to a training experience.

Training of volunteers who would work with adults needing protection includes:

(1) General exposure to the overall agency's mission, goals and purposes with particular emphasis on Adult Protective Services.

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*The Fairfax County (Va.) Area Agency on Aging currently recruits volunteers to serve as Court appointed guardians to mentally impaired clients of the local Department of Social Services. These clients are wards of DSS. The volunteer works under supervision of the Adult Protective Service worker whose client becomes the ward of the volunteer guardian. Reported in "Human Development News" a publication of the Office of Human Development Service, Office of the Secretary, DHHS, Washington, D.C. December 1980 p. 9.

The AOA is currently supporting a project to train and evaluate volunteer representative payees in the District of Columbia.

(2) Providing the volunteer with some understanding about the characteristics of the people served and the type of services provided.

(3) Helping the volunteers to deal with their own feelings about the type of people they will be working with and the type of situations which they, as volunteers, will likely encounter in the course of their activities.

(4) Giving them some beginning insights about human behavior and the psychodynamics of the social, medical and legal aspects. This might include dealing with manipulative individuals, mentally retarded adults, mentally impaired aged; clinical depression in adults, dependency attitudes; and biases in both clients and staff with whom they work.

(5) Outlining the opportunities and limitations involved in working with other disciplines such as medicine, law, nursing and psychiatry.

(6) Helping them to understand the nature of social and legal interventions and clients' rights.

The content of this section on training volunteers is equally applicable for training social service staff of the State/local public service agency.

Case Termination

This section deals with the processes necessary to terminate a social service case in a public social service program. It does not deal with termination of guardianship or other legal process or procedure. States cited below are examples.

The following criteria for case termination have been identified by States in their service manuals:

1. The presenting problem has been alleviated and there is no further need for services as determined by case-worker. (New York, Nebraska, Kansas.)
2. The client condition is stabilized without legal controls or need for protective social services and client is transferred to other general support services. (New York, Nebraska, Kansas.)
3. The responsibility for the client has been assumed by another agency. (New York, Nebraska, Kansas.)
4. The responsibility for the client has been assumed by family (relatives) or friends. (New York, Nebraska.)
5. The client (or legal representative) refuses the agency's services, or challenges the agency's legal right to intervene. (Nevada, Nebraska, Hawaii.)
6. Abuse, neglect or exploitation of the client have been eliminated or reduced to the extent that the client's needs are being sufficiently met and he is removed from threat of danger. (West Virginia, Arizona, Alaska.)
7. Client no longer meets eligibility requirement, adult requires more care because of mental, physical or financial condition than can be provided through adult protective services, or client desires to terminate service. (Iowa.)
8. Unsubstantiated reports. (Nebraska.)
9. Client dies. (Nebraska, New Mexico.)
10. When the goal of the service plan is reached. (New Mexico.)
11. Client moves out of the county or the State. (New Mexico, Hawaii.)
12. Client is non-cooperative or cannot be located. (New Mexico.)
13. Client and worker together decide services are no longer needed. (Alaska.)

It is worth noting how varied are reasons for case closure. Ten States which spoke to case termination in their manuals produced 13 reasons for closing the case. Fewer than five States adopted any one criterion for closing the case.[74]

One of the grey areas around client's refusal of service has to do with the voluntary nature of the client's acceptance of service. Older people, particularly, may wish to assert their self-sufficiency when, as a matter of fact they are very dependent. Caution in accepting an elderly client's refusal of service is indicated. When there is any doubt another professional opinion should be sought, rather than an abrupt withdrawal of service and case termination.

It is much more consistent with the use of the dual social intervention/legal intervention

approach to attempt to develop a rapport with the individual so he will willingly continue to accept services and become a voluntary client. Furthermore, a voluntary client upon regaining mental health after treatment can much more easily return to his home from the mental hospital. These would be preferable to simply terminating a needy case.

The agency has a resource where this is not possible by taking action to secure court examination and possible placement in a protected setting. This action is involuntary. It does, however allow the agency, in cases where there is any doubt, to continue to protect people even contrary to their own expressed wish, and to avoid simply ignoring or withdrawing from harmful situations.

It is important when case termination is being considered to consider these options.

Complaint Investigation, Reporting and Actions

A fundamental right of our citizens is protection of person and property.

Protective Service includes services to adults who have been abused, neglected or exploited as defined by each State. States define abuse, neglect and exploitation. States also outline procedures necessary to verify the fact of abuse, neglect or exploitation of an adult.

Where abuse, neglect or exploitation of an adult is a crime under State law or local ordinances, the steps necessary to verify facts and report the facts to responsible authorities for remedial action and possible criminal prosecution are carefully outlined in State manuals.

Inasmuch as there is the possibility of recurring patterns of abuse or neglect or exploitation, States are establishing central registries to assemble data on abuse, neglect and exploitation of adults.

Since numerous older adults and aged persons dwell in a variety of institutional settings which may be medical or non-medical (social care institutions) in nature, some States have outlined a comprehensive investigation process to document abuse and neglect in such settings. (South Dakota, New York).

One aspect of abuse and its treatment under Adult Protective Services deserves comment. Some States include parent and child abuse by spouse a part of Adult Protective Services. Other States prefer to deal with this matter under the title of domestic violence. Since the roots of this pattern of abuse spring, not from the notion of criminal abuse against aged individuals with serious mental impairment or advanced age and/or senility, but from family discord, it would appear that abuse springing from domestic violence should not necessarily be classified within the framework of Adult Protective Services. (This matter is mentioned earlier in this document under Client Characteristics, Chapter II.)

Finally, action taken as the result of an investigation may involve the use of social interventions such as: warning the caretaker or the exploiter; quickly removing the individual from a hazardous setting such as unsafe and infested housing; establishing a home-delivered meals program to ensure regular eating habits and a nutritious meal; getting Social Security checks reissued if the form of abuse is absconding with the client's social security payments.

If the individual is being victimized by a caretaker, it may be necessary for the State/County Agency to resort to legal action to have the caretaker removed. It may also be necessary to secure the assistance of law enforcement authority—the police—to enter the home and remove a person from a situation which is potentially dangerous to him. A court order must be secured to enter the home. Some States (New York) give the local Department of Social Services the authority to call upon the police if necessary to enter and remove the person from a harmful situation.*

General Policies on Investigating Complaints

Essentially, States, in general policies, set out the purposes and goals for dealing quickly

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*(See New York Social Service Law, Sect. 131.L. Mental Hygiene Law Article 9, Sect. 31.41, 13-45). Re: Elder Abuse, For those who wish to pursue the matter further refer to the report on Elder Abuse prepared by Ms. Kathleen Gardner and Val. J. Halmondaris for the House of Representatives Select Committee on Aging (Claude Pepper, Chairman) April 3, 1981, Committee Print No. 97-277. U.S. GPO, Washington, D.C. 1981

with complaints and follow-up investigations received and with problems of entry into homes being investigated.

The State of New York directs that if at the initial contact whether by telephone or in the intake office it is determined that there is imminent danger, the following steps are to be taken: alert the protective services unit or caseworker and take steps to remove the client from harm. If the client resists, rely on the Mental Health Director of the Community Services Office, who has authority under State law (Apt 13 -Sect. 31-37) to have the person temporarily removed to a hospital or other place of safety. Use police if necessary to remove the person from a situation where there is potential harm to self or to others. (Refer to the earlier section on the Individual Service Plan.)[75]

The State of Iowa points out that the purpose of the investigation is to determine the client's need for protection and to determine those available services and resources which will alleviate the client's need for protection. The investigation should include factors contributing to the problem, the client's perception of the problem and his ability to alleviate the problem. The investigation report should show all available appropriate community resources and contain a recommendation as to the disposition of the investigation.[76]

The State of Oklahoma, in its statute on protective services for the elderly, makes it clear that the Department's investigation shall include a visit to the elderly person's home and consultation with persons who have knowledge of the circumstances. When in the course of an investigation of this nature the department is denied entrance to the elderly person's home, the department may petition the court for an order allowing entry. When it is necessary to forcibly enter the premises, the representative of the department may make the entry accompanied by a peace officer.[77]

Referral of Cases for Protective Service

The State of Alabama in its 1977 law (Act 780) to prohibit the abuse, neglect or exploitation of aged or disabled adults, made it clear that the department administering the law shall seek out through investigations, complaints from citizens or otherwise, the adults who are in need of care and protection because of danger to their health or safety. This implies making referrals for protective service a routine procedure.[78]

The State of Louisiana breaks down the referral into four parts: (1) services requested by the individual or by a third party with the knowledge and consent of the individual, (2) services requested by a third party without the knowledge and consent of the individual, (3) services requested by a third party, where the individual is unable to participate in the investigation, and/or is unable to give consent for and/or agree with the provision of services, (4) services requested by, or on behalf of, an individual when a third party is reported to be neglecting, maltreating, or wasting the resources of the individual, or depriving the individual of entitlements. In an exemplary fashion, the State outlines the worker's role and responsibility in these differing referral situations. (See Appendix P.)

The State of Oklahoma, in its statute, points out that any person willfully or recklessly making a false report without a reasonable basis in fact for such a report, under the provisions of the act will be liable for a civil suit for any actual damages for the person so reported, also, any punitive damages.[79]

Investigation

The State of Arizona requires that all initial reports, oral or written, shall be investigated by an Adult Protective Service worker. The source must provide information concerning the nature and extent of abuse, neglect and exploitation.[80]

The State of Washington conducts investigations of adults who are abused, neglected, exploited and living in unsafe or unsanitary conditions on the day received; on neglect, within two working days; on exploitation and unsanitary conditions within five working days.[81]

The State of Nebraska requires that when the law enforcement agency, abuse/neglect hotlines, or other sources refer a complaint of suspected abuse or neglect to the service unit for investigation, the service worker shall contact the alleged abused neglected adult(s) cited in the complaint as soon as possible as well as any interested individuals (e.g. the caretakers, guardians or relatives), determine whether emergency intervention is required, determine whether the report is unfounded or whether further investigation is required and, in any case, submit the report to the central registry.[82]

The State of New Mexico outlines some criteria for identifying abuse/neglect and exploitation. Services are provided in order to prevent or remedy the injury or deprivation that renders an adult abused, neglected or exploited.

An adult is abused or neglected if the following conditions are found:

1. He is either suffering or probably will suffer
   (a) serious physical, mental or emotional harm; or
   (b) a lack of the minimum food, clothing, housing, medical care, or dental care necessary for mental and physical health; or
   (c) a wasting of his resources or deprivation of a public entitlement.
2. He is incapable of caring for himself or protecting his property interests for the following reasons:
   (a) serious physical handicaps
   (b) mental retardation
   (c) diminished mental or physical capacity due to old age
   (d) mental illness
   (e) alcoholism
   (f) drug addiction

An adult need not be legally incompetent in order to be "abused or neglected". An adult is exploited if:

1. he is incapable of caring for himself or protecting his property interests, and
2. he unjustifiably has been or is being denied a fundamental personal freedom or the benefit of his own property interests without his knowledge or intelligent consent.

Such exploitation includes the wrongful conversion of his property, and the crimes of kidnapping, false imprisonment, larceny, fraud, embezzlement and extortion. The adult need not be legally incompetent to be "exploited".[83]

The State of Maryland, in its statute on Adult Protective Services, indicates that investigation shall include:

1. Face to face interview with the adult
2. Information gathered from the adult and collateral material.[84]

The State of Alabama points out the sensitivity of investigations as follows: If signs of abuse, neglect and/or exploitation are detected, the service worker must attempt to discover the true state of affairs, keeping in mind that the purpose of the investigation is protection of the client, not punishment of anyone. It is important that facts be distinguished from hearsay and rumor.[85]

The State of Kentucky has some exemplary criteria for evaluation of the adult being investigated. (See Appendix N.) The criteria cover demographic information, information on the physical and social environment; physical health, mental health, adult functioning, economic situation and social worker's assessment.[86]

The State of South Dakota also outlines in a commendable fashion the basic steps for an investigator to follow in investigating a complaint of abuse or neglect of an adult in an institutional setting. (See Appendix O.)[87]

The State of New Hampshire, in its protective program, emphasizes investigation of adults needing protection because of abuse, neglect or exploitation and organizes the general and specific characteristics to be noted as follows:

a) Characteristics of all neglect, abuse, exploitation and hazardous living situations include:
   (1) the abused adult's physical, mental or emotional deficiency that renders him

or her incapable of managing himself or herself or his or her affairs

(2) the degree of danger to the neglected, abused or exploited adult residing in a hazardous living situation

(3) the perpetrator's role in the neglect, abuse or exploitation of the adult

b) Characteristics specific to adult abuse

(1) the pattern and non-accidental character of the injury

(2) the perpetrator's role in the alleged abuse

(c) Characteristics specific to adult neglect:

(1) the neglected adult's pattern of conduct that reflects deprivation of services that are essential to minimum mental and/or physical health

(2) the absence of a reliable and adequate protective source

(3) the caretaker's inability, unwillingness or unaccountability for the arrangement, provision or acquisition of the services essential to the neglected adult's well being.

d) Characteristics specific to adult exploitation:

(1) the improper use of the incapacitated adult or his or her resources

(2) the taking or disposing of the incapacitated adult's resources without approval or under false pretenses and for another's profit or advantage.

(e) Characteristics specific to the hazardous living situations of adults are:

(1) the adult's willingness to correct the hazardous living situation

(2) the availability of resources to correct the hazardous living condition and maintain an appropriate living situation.[88]

The investigation of a complaint that an adult is neglected, abused or exploited is a very important function in Adult Protective Service. We note that many States define the terms abuse, neglect or exploitation; some States go further, to outline characteristics which are specific to abuse, neglect and exploitation of adults. Some States have done admirable work in preparing their workers by providing training illustrating the important questions, and suggesting how they should be asked in investigations. Knowing how to conduct an investigation and being sensible and sensitive about it is a key to good practice in the provision of protective services to adults.

Reporting

Examples of State requirements for reporting complaints of neglect, abuse or exploitation follow:

The State of Nebraska, in its policy manual, refers to its statute (Sect. 28-711, RRS 1943). This statute provides that when any physician, medical institution, nurse, school employee, social worker or any other person has reasonable cause to believe that an incompetent or disabled person (as defined in their manual) has been subjected to abuse or neglect, or observe such person being subjected to conditions or circumstances which reasonably would result in abuse or neglect, he/she shall report such incident or cause a report to be made to the proper law enforcement agency or to the department on the toll free number. The agency will then follow up and investigate. Arkansas has a similar provision in its statute. (Act 166 of 1977).[89]

The State of Washington provides for reporting and investigation of complaints about abuse or neglect of clients by Department of Social and Health Service employees or volunteers in or out of institutions run by the State.[90a]

The State of Virginia quotes State law which states that "any person, including but not limited to any physician, psychologist, nurse, teacher, social worker, employee of a public or private facility serving developmentally disabled persons, or a parent of such persons, who has reason to believe that a developmentally disabled person has been subjected to abuse shall report or cause reports to be made to the Department (of Health and Rehabilitative Services)".[90b]

The need for good reporting of cases of adults needing protection cannot be overemphasized. An isolated incident or a pattern of abuse only becomes known if it is reported. The study that follows the receipt of such report provides the documented evidence necessary to support a proposal for legal action, which may be initiated by the law enforcement authority only on the basis of factual information.

Nineteen States have abuse-reporting as a component in their laws dealing with Adult Protective Services. Physical and mental abuse of nursing home residents is an issue which has received continuing attention over the years. A recent report (January 1981) on the long term care ombudsman program prepared by the LTC Ombudsman program staff of the Office of Program Development, Administration on Aging, DHHS, Washington, D.C., identifies some substantive requirements in States related to this area. States are requiring mandatory reporting of abuse, neglect and exploitation, protection of the confidentiality and freedom from liability of persons reporting abuse, and creation of statewide mechanisms to investigate such reports as well as provision for emergency intervention in life-threatening situations.[90c]

Gaining Access to the Client and Entry to Home of Abused, Neglected or Exploited Adults

Upon a referral complaining that an adult is abused, neglected or exploited, State agencies usually require an investigation. This means visiting the adult allegedly being abused in his/her home. This section concerns agency policies dealing with this situation.

The State of Iowa in its policies on adult protective services points out that home investigation of complaints is to be provided by securing the voluntary cooperation of the client and his family. The service worker is to obtain entrance to the client's home by providing identification and stating the purpose of the service. Should the adult client refuse service or deny the need for protection, it is the worker's responsibility to continue to offer voluntary services in a non-coercive manner. If the client objects to the worker's continuing presence, the worker may need to consider possible legal action to provide protection for the adult prior to terminating the service.[91]

The State of New Hampshire outlines a procedure similar to that suggested by the State of Iowa. The emphasis is on persuasion and use of relatives to convince the adult that an investigation should be allowed. Recourse to the police is the next step when entry to the home of an adult who manifestly needs protection is denied. In extreme danger or an emergency situation, the court is petitioned for temporary guardianship.[92]

The State of Nebraska points out that when an adult refuses entry and there is reason to suspect that the adult is dangerous to him/herself or others the service worker shall contact the law enforcement agency or the county attorney to request assistance as needed. [93]

States have taken different paths to move on situations where entry is resisted or refused. Again, the unique characteristic of protective service is the potential for the use of legal authority.

Immunity of Reporters—Limitations

Individuals who report abuse are very vulnerable both as to criticism by those whom they have reported and because of the possibility of civil suits for defamation of character or libel, etc. Some States provide for immunity of the complainant in complaint referral. This section will deal with State policies on this subject.

The State of North Carolina in its statute dealing specifically with protection of abused, neglected or exploited adults provides that anyone who makes a report or who testifies in any judicial proceeding arising from the report or who participates in a required evaluation (of the need for protection) shall be immune from any civil or criminal liability on account of such a report or testimony or participation unless such person acted in bad faith or with a malicious purpose. Virginia

provides for protection of the reporter in a similar manner.[94]

The State of Florida in its Adult Protective Services Act (June 1, 1977) on immunity of complaint reporting indicates that any person who reports (or causes to be reported) an alleged abuse or neglect situation or participates in a judicial proceeding resulting from a report and investigation...shall be presumed prima facie to be acting in good faith and in so doing shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed.[95a]

Although the law grants immunity to individuals reporting abuse of adults, States do not generally grant immunity for reporting cases of neglect or exploitation of adults. Whether this is a legal oversight, or the question of reporting neglect or exploitation has not surfaced because of limited reporting of neglect or exploitation, or neglect or exploitation are not physically violent is not clear.

Statistical data on the volume of abuse, neglect or exploitation of adults is limited. Those States having central registries which maintain data on abused, neglected or exploited adults are few in number.

The unwillingness of individuals to report situations of abuse stems in our opinion as much from current attitudes of people in contemporary society which wish to avoid becoming involved as it does from fear of reprisal on the part of perpetrators of abuse, neglect or exploitation. Possibly the individual who can report neglect or exploitation and retain anonymity feels secure.

It is interesting to note as one random example the State of Connecticut statistics on this area for the 3-month period, March through May 1979. They showed that 82% (158 cases) of the cases opened in their protective services caseload were for neglect, 13% (26 cases) were for abuse; 4% (8 cases) for exploitation and 1% for abandonment—a total of 194 cases in all.[95b]

Taking Action on Complaints after Investigation—Limitations

This section will concentrate on State policies related to action to be taken following the investigation of a complaint that an adult has been abused, neglected or exploited and needs protection.

The State of Kansas identifies in an exemplary manner, a series of service tasks which are to be undertaken as appropriate to achieve the goal of protection, once the investigation indicates the need for it. (See Appendix Q). The service worker is the person primarily responsible for directing, coordinating and managing the program of services needed by the client. The point is made that the service worker cannot, nor is expected, to directly provide all the services which a client may need. The service worker however identifies and draws upon other Social and Rehabilitation Service Agency and community service resources. Note the charge to the service worker is related to the section above on case management in Chapter II.[96]

The State of Oklahoma suggests that in taking action following an investigation the least restrictive service should be employed.[97]

The State of Arizona deals with two types of individuals needing protection—the incapacitated person harmed or threatened with harm; and the case where the caretaker or guardian is abusing, neglecting or exploiting the adult.

In the first instance the State defines an incapacitated person as "any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication or other cause...to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person". (ARS s.14-1501)

In the case of the incapacitated person the agency directs the adult protective service worker to take steps to initiate voluntary protection of the person, or take action to file a petition for a conservator and/or a guardian.

In the second instance the adult protective service worker should file a petition for a

temporary guardian and/or removal of the present guardian. In no case will an adult protective service worker be appointed as a guardian.[98]

The State of Nebraska provides for emergency intervention when the service worker determines that the adult is in immediate danger by contacting the law enforcement agency (county sheriff) at once to request assistance in obtaining medical care, or alternatively to request the county attorney to petition the county court to exercise the power of emergency guardian to order needed treatment.[99]

The State of West Virginia covers the need for authorizing medical treatment for an individual who is incapable of doing so and who has no relatives or others willing to do so.* Under no circumstances, states the policy, should the worker consent to authorize medical treatment. The worker should refer the referring physician to the State Director of the Division of Medical Care for advice as to how to proceed.[100]

These citations note the tasks which States direct the adult protective service worker to perform; the differences in procedures for emergency intervention, the types of individuals who may need protection and the ways in which the State policy deals with them. The limits on social interventions are very real and are established to protect all parties to the protective service intervention.

An exceptionally interesting approach to taking action in response to a complaint of abuse, neglect or exploitation of the elderly is outlined in the Connecticut State Department of Social Services manual.

The Connecticut State Department on Aging handles intake service for the elderly who need protective services. An Ombudsman will be responsible for accepting all telephone calls and other complaints of alleged abuse, neglect or exploitation and determines if the complaint meets the requirement of the statutory definitions (See Conn. Public Act. 77.613 Sect. 4). The Ombudsman will make a prompt and thorough evaluation of the reported situation. The Ombudsman will determine after a home visit (a) if there is abuse, neglect, exploitation or abandonment (b) if protective service is needed and how to resolve the situation if known.

The Ombudsman can, alternatively, find that protective services are not necessary; if he/she determines that protective services are necessary then the elderly person will be informed of their findings.

If the elderly person does not consent to protective services and the ombudsman deems that the person is capable of managing on his own the case will ordinarily be terminated.

If the elderly person does not consent and is deemed incapable of handling such a decision, the Ombudsman will note the facts in the case and refer it to the Department of Social Services for action, and so inform the elderly client.

If the complaint and subsequent investigation indicates that the elderly person is in an emergency situation needing protective services, the Ombudsman will attempt to resolve the emergency. After contacting the caretaker or any relatives able to take immediate action if neither are available to act in the emergency, the Ombusdman will refer the case to the Department of Social Services District Director or the person designated to handle the emergency. The Ombudsman must obtain consent from the elderly person to refer the case.

The severe conditions outlined above emphasize the need to respect the capacity of the elderly person to consent to protective services in an emergency situation.[101]

The discussion in the section above on terminating cases is also relevent here. It is important to be sure that the Ombudsman/service worker be perceptive in judging the client's ability for self management.

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*There is an interesting article in the American Journal of Psychiatry (134:3) March 77 on competency to consent to treatment. Various tests are outlined and the difficulty of applying them are outlined. See Roth, Meisel and Lidz, "Tests of Competency to Consent to Treatment." pp. 279-283.

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Social and Legal Interventions

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Chapter IV

Social and Legal Interventions

Introduction

States have always provided some form of protective service to their clients since the beginning of the Social Security Act in 1935. For many years social protective services, that is, casework services with a goal of protection, were carried out under Public Agency auspices. The statute which established the State Department of Public Welfare was considered sufficient authority for these social interventions on behalf of recipients of public assistance who were aged, blind or disabled recipients of the Public Welfare Department.

Private Voluntary Agencies at the National, State and local levels have been equally concerned about the protection of adults, particularly the elderly, over the past half century. A survey conducted by the Community Service Society in the early 60's indicated that as many as one in every five elderly people in New York City in the sample survey was in need of some assistance with personal or financial management. In many instances local family service agencies undertook to carry out protective services on behalf of their elderly clients. United Charities of Chicago gave considerable leadership in developing protective services to the aged through the development of innovative practices and techniques. Currently, social protective service interventions are carried out in all States administering the Title XX program.

Role and Responsibility of State/Local Departments of Social Service

As practice improved and social and legal interventions developed, States began to recognize the unique quality of protective services, with its potential for the use of legal authority, to deal with the problems of its clientele whose behavior or whose situation indicate a need for protection. States are clear about their responsibilities to provide protective service, as is indicated in the remainder of this chapter.*

As indicated earlier, an essential and overriding distinction between a protective service and other social and health services is its potential for legal authority. The point is "that if legal action should be required the agency needs to be empowered, equipped and willing to undertake it."[1a] Legal authority is emphasized in the following considerations.

States and their local counterparts have a responsibility to provide protective services in Idaho even though there are fewer laws, State or Federal, which pertain specifically to the abuse, neglect or exploitation of adults than there are for children.[1b] The Kansas Service manual points out that even without such a sanction in law, adult service staff have been providing this service for years under various titles such as casework, social work, etc.[2] South Carolina states that the Department of Social Services is charged with the responsibility of providing protective services to its citizens. Under the law if a person in need of this service does not voluntarily accept it the Department may petition the court to exercise placement of the individual for purposes of care and custody.[3]

Georgia gives five responsibilities to its Department of Family and Children Services for providing protective services to adults. They are:

1. Complaint investigation of reports of abuse, neglect and exploitation to determine the validity of the complaint and whether the intervention of the Department in behalf of the individual is necessary.

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*See: Helen Turner, "The Public Agency as the Social Guardian of Aged Persons" in Pennsylvania Citizen's Council Conference on Protective Services for Older People. (Wash. US. PHS, 1965), for a consideration in depth of the State's responsibility for the welfare of the brain damaged citizen.

2. Arranging for guardianship when the Department has determined that protective services are necessary and the client refuses to accept them; or commitment, as indicated.
3. Arranging for appropriate alternate living arrangements and transportation.
4. Providing related social services through the counties.
5. Identifying unmet need and developing resources.[4]

In New York the local departments of social service assume the responsibility for creating a community awareness of the urgent need for protective services for adults. This effort would lead to earlier identification and referral of these adults at risk and prevent or reduce the incidence of tragedies.

Although there is no requirement for a separate administrative unit to handle protective services at the county level, it is important that there be specific assignment to protective services for adults at all staff levels.[5]

It is clear that most States appear to have established roles in providing adult protective services either under law, administrative fiat, or as a component of regular agency casework practice. The local agency is expected to provide this service in those States which provide Adult Protective Service to all who ask for it. or are referred by third parties, including the family, the police, other social agencies or concerned individuals.

Social Interventions

States providing adults these services normally identify protective services narrowly, as a discrete service. As such they usually consist of caseworker activity and the use of referral to other agencies for the medical, legal and the social services not provided by the agency.

However, some States provide for "clusters" or "mixes" of individual, discrete services which, together, constitute Protective Services. Such a "mix" of services may include, but is not limited to transportation services, legal services, casework services, and other ancillary services "as needed." Since most individuals pose problems which require individualized service responses, the "mix" of services may differ for each individual. As examples, social welfare services are provided for such purposes as meeting a need for emergency housing, or to deal with elderly mentally impaired persons who may need medical diagnosis (including psychiatric diagnosis) or institutional placement to protect them from harm. Aged persons may simultaneously require housing and medical care and chore service. As indicated in Chapter III, States define the service "mix" they offer and the conditions of eligibility in their jurisdictions. There are numerous examples of conditions and circumstances in which people are found which require action on someone's part to literally remove them from an unhealthy or dangerous situation or to rescue them from abuse, neglect or exploitation. (See also the section on eligibility, Chapter III, for consideration of how eligibility is affected by how protective service is defined).

This section will consider the nature and type of social welfare services provided, the components of protective service; service methods; social care; services provided in crisis or in an emergency; (they may be identical); service outcomes, expected and actual, and methods of maintaining records which can be utilized to determine the volume of abuse or neglect as a basis for subsequent action to prosecute perpetrators of such abuse or to remove an individual from an abuse situation.

This section will allude to legal interventions for clarification purpose only. Issuses between social and legal interventions are considered in Chapter V.

Nature and Type of Social Intervention

Social interventions for protection of clients involves the caseworker not only in direct services, but as case manager in coordinating necessary service programs, in resorting to consultants and specialists where needed, and as service community member in working cooperatively with other public services. Legislative directives also influence the caseworker actions and how the caseworker may be empowered to utilize authority within

defined responsibilities. Definitions and guides cannot encompass the human situation or the actual personal responsibility and exercise of judgement the social worker must personally bear. In the factual materials which follow some repetitions from earlier Chapter III occur which serve to highlight their significance.

Social Intervention means the assistance furnished an individual, using social welfare services exclusively, to protect him/her from harm. Earlier in this monograph, the characteristics of individual clients needing protection was discussed.

Insofar as it is possible to do so, it must be recognized through the course of the socially interventive protective case action that the client has certain rights which must be respected. Utilizing advice, persuasion and encouragement, the client is motivated to leave unsuitable living quarters; encouraged to take a medical or psychiatric examination, assisted with money management. The competent client should never be forced against his will to consent to any action "in his best interest." Services should not be imposed on clients.

One characteristic of practice in Adult Protective Service is the ability of the worker to utilize professional consultation in dealing with situations involving medical and legal ethics and practice.

Adult protective service workers need to and should utilize the resource provided by other professional disciplines in dealing with sensitive issues involving clients in their charge. Also, in determining the capacity of a client for self care the use of a physician, psychiatrist or a psychologist to test the mental, emotional or behavioral state of a client is recommended to the Agency. In addition to functioning in their own profession, doctors and lawyers can serve as consultants to the case manager on puzzling situations which are related to medical or legal interventions. The employment of legal intervention is an instrument of the social intervention.

In dealing with the abuse, neglect or exploitation of clients in the home, where the service worker is denied contact with the principal party, the Adult Protective Service worker who is unable to gain access or entry to a home to verify abuse or neglect on his own must rely on the law enforcement authority to gain entry. States have indicated in the policy guides what needs to be done to secure the cooperation and help of the police in such situations. In many situations where abuse, neglect and exploitation is alleged, a court order is necessary to allow law enforcement authorities to act.

Although this monograph is not concerned with standards enforcement as such, wherever possible administrators of Social Service departments should lend the weight of their authority to support the State's standard setting authority in enforcing standards of health, safety, sanitation and humane treatment.

Recently the need to deal with suspected abuse and neglect in institutions has been recognized but the difficulty of gaining entry has posed great problems. In verifying abuse and neglect in such facilities, the State must be prepared to document its findings. The Ombudsman program can be usefully employed in nursing home investigations. The development of the LTC Ombudsman program under Section 307(a) 12 and (16) and 321 (a)(10) of the Older Americans Act, as amended in 1978, has provided the Adult Protective Service workers in States administering the Title XX program with a useful resource as they carry out their protective service activities. Proposed HCFA Standards strengthen ombudsman intervention into nursing homes.

The types of service used will affect the nature of social intervention practice.

The protection initially offered to adults in most States is voluntary in nature (Arizona).[8] This means no one unwilling to accept help, no matter how urgently requested, receives it.

In considering protective services, North Carolina in its statute defines "essential services" needed by adults with physical or mental impairments, including the developmentally disabled adults. "Essential services" refers to those social, medical, psychiatric or legal services necessary to safeguard such adults' rights and resources and to maintain the physical or mental well being of the individual (Cluster of Services).[9]

The State of Kansas advises that it is important for social service workers to remember that the objective of protective service is to respond to the needs of the client as well as to his/her inability to ask for help.[10]

One needed resource in protective service activities as practiced in States is the protective service emergency fund. South Carolina shows that this fund can be used for the purchase of services not otherwise available. Such services would include health related services such as medical examinations and treatment, nursing home care, and other necessary services.[7] The presence of an emergency fund which can be used for a variety of purposes is an innovative and an exemplary practice. Unfortunately, protective service cases often erupt at times of day and over weekends when the normal agency resources are unavailable. If a client has to be housed temporarily until a plan can be made for a more permanent placement, the existence of an available fund to pay hotel bills is a real resource.

The State of Alabama argues for preventing the need for protective service by preventing the kind of physical deterioration and crises that necessitate provision of protective services. The State indicates that service workers need be especially sensitive to potential dangers that can be ameliorated but which if left unattended can result in the client's breakdown. A skilled service worker might recognize strained family relationships that are threatening to make a young family decide they can no longer keep a grandparent in the home. Day care for the elderly adult might provide the relief needed, or casework services that enable family members to understand each other better might make the situation tolerable. The State concludes: If we can overcome blocks to seeking casework services before a crisis situation develops, much can be done to prevent breakdowns that require the use of protective services.[11]

Staff delivering this service need to be thoroughly trained to work in this very labor-intensive service area. The type of services which are marshalled by the service manager/caseworker may include social casework, homemaker/chore services, home delivered meals, transportation, medical and remedial care, housing services and many others. The use of social, medical and legal services individually or in concert is common. The use of professional consultants is recommended.

Because this service deals with individuals who may be emotionally or mentally disturbed, chronically ill, violent, depressed, and eccentric, the number of cases that can be treated at one time by the adult protective service worker is limited. One State has suggested an active caseload of 35 cases at one time. Even this may, over time, be too heavy a burden because of the intensity of the emotional content with which the caseworker may have to deal. Caution is suggested in assigning too many cases because of "burnout." Staff rotation in and out of protective service units could help to alleviate the drain on caseworker's capacities to handle this type of client. There is need for highly skilled leadership for adult protective service "units" at the local level. Case allocation activities, quick judgemental decisions based upon knowledge of agency policy, good working relationships with other service units in the agency, with other human service agencies and with the courts and law enforcement authorities, necessitate this kind of leadership position. It is well worth the cost to pay for this case manager as he/she is the key to a successful operation of one of the most difficult and trying service areas in the entire range of agency services.

It has been suggested that State Agencies might be advised to consider local sector agency experience in setting caseload size. A great deal depends on the availability of specific social, medical and psychiatric services, distances to be covered, etc. (See Chapter III -Caseloads Standards).

Content of Service

Earlier in this document the scope of services to provide protection to adults in the public social service programs was outlined. This section is concerned with those activities and services provided in the case plan to carry out social interventions by the public agencies administering Title XX or services under

some other programs such as the Older Americans Act (as amended).*

The content of service comprises any or all of the activities and services mentioned above, individually or in concert, which are marshalled by the agency service manager, utilizing professional consultation and other community organization techniques and carried out in cooperation with or on behalf of an adult requiring protective intervention. Any program review of local county protective services undertaken by the State would likely identify the content of service provided to each individual client by the agency for his protection as a measure of the type and quality of service delivered.

Some States have provided a combination of activities and direct services by agency staff. Other States have a blend of agency activities which facilitate access to services provided by other human service agencies. Still other States provide an organized cluster of services which are available to provide protection.

In most States casework/case manager services are the core of the protective service function.

Maryland, for example, in interim guidelines for protective services to adults, indicates that both social and legal interventions are carried out. In addition to recognized activities such as investigation of reports and assessment of client needs and capacities, social interventions in the form of services include formulating and carrying out a service plan which may include social work counselling; homemaker/aide service; referral to resources for housing, health, legal services and other needs.[12]

The components of Adult Protective Service in Nevada include receipt of abuse/neglect reports and following investigations; counselling with adult and family members, arranging for necessary medical examinations and legal representation, provision of transportation and arranging for the provision of a number of other supportive services such as placement, employment, homemaker, etc.

*Restrictions on caseworkers' activities in the absence of a legal base is outlined in the section on Legal Base below.

Services offered to clients must be accepted voluntarily by the client except where court-ordered. A number of States, (Nevada, New Mexico, etc.) terminate service when either the client or his representative refuses service or the agency's legal right to intervene is challenged (See Chapter III).

The State of Hawaii discusses in some detail in its service proceedural material the casework/counselling activites followed in providing social protective services to adults. (See Appendix A).[13]

The State of Iowa has a policy which indicates services that will be provided without regard to financial or categorical eligibility which include: adult protective investigation, adult day care, in-home service, homemaker service and transportation services. Other departmental services may be provided if the client meets categorical or financial eligibility service requirements.[14]

The State of Washington shows that major activities in providing adult protective services include counselling with the client and any other individuals included in the situation; removing individuals from hazardous situations; assisting the client in securing medical care or mental health services; helping the client find alternate housing; assisting abused persons fleeing from their homes; arranging for guardianship or other legal assistance; arranging for homemaker, chore or volunteer services such as handyman services, transportation, friendly visiting; contacting law enforcement officials; and referring the client for placement in Skilled Nursing Facilities (SNF), Intermediate Care Facility (ICF), Congregate Care Facility (CCF), or Adult Family Homes (AFH).[15]

The State of New York comendably has listed the content of services provided under Title XX in its service manual (See Appendix R). These services, identified under the following headings (a-i) are provided without regard to eligibility. Other adult services listed in the CASP which might be used in a case plan for adult protective services are also listed below.

Services to individuals 18 years of age or older who are unable to protect their own interests, harmed or threatened with harm, include:

(a) Identifying such adults who need assistance and have no one willing and able to help.

(b) Providing prompt response and investigation upon request of adults at risk or other persons acting in their behalf.

(c) Diagnosing the individual's situation and service needs.

(d) Providing counselling to such adults, their families, other responsible persons or to surrogates.

(e) Arranging for appropriate alternative living arrangements in the community or in an institution.

(f) Assisting in the location of social services, medical care, and other resources in the community including arranging for day care in a protective setting.

(g) Arranging for guardianship, conservatorship, commitment or other protective placement as needed.

(h) Providing advocacy and assistance in arranging for legal services to assure receipt of rights and entitlements due to adults at risk.

(i) Functioning as a conservator, representative payee, or protective payee when it is determined such services are needed and there is no one else available or capable of acting in this capacity.

Use of Other Adult Services

Other New York State services listed in the CASP which might be used in a case plan for protective services for adults are:

Family Planning Service	Housing Improvement Service
Foster Care for Adults Service	Information and Referral Service
Health Related Service	Preventive Service
Home Management Service	Transportation Service
Homemaker Service	Unmarried Parents Service
Housekeeper/Chore Service	

In the use of these services the programmatic and income eligibility standards as elected by the local district will apply. [16]

As can be seen from a review of State service components there is some variation in the ways States carry out service provision. The needs of adults for protection may require the use of a number of social, medical and legal components. Some are intrinsic functions of the casework process through procedures to assist or arrange for service. Others are individualized service functions like homemaker service which can be provided by the agency as a direct social service, can be purchased or may be available without cost from other programs (Title XIX SS Act). Medical or psychiatric diagnosis and treatment may be needed, which may not be available in the public social service agency but is available to the public service agency from a hospital, medical clinic or other health facility. The legal components of protective service such as guardianship or commitment may be available as a part of legal services carried out by the State agency or through other organizations and individuals who are qualified and who are prepared to carry them out.

Medical Aspects of Social Intervention

Adults referred to State/local public service agencies for protective service may have physical or mental impairments of greater or lesser severity. It is a normal part of the protective service process to have a medical examination, assessment or evaluation of the individual concerned to determine the nature of any impairment and its severity. Many adults on the continuum from well being or mental health to physical or mental illness need to be examined to determine where they fit on that continuum. The caseworker/case manager should consult with a physician on the most effective approaches to the use of the health care system as a part of the overall protective case action.

In those instances where a complaint of abuse is made by a third party some States require the examining physician who determines that the individual has been battered or injured by a caretaker, to report

the situation to appropriate authority. (See Chapter III).

Physicians are also called upon by the Court to conduct a medical examination in cases where institutional commitment or guardianship is being considered, particularly in incompetency hearings. Since there is need to make a medical determination of physiological or psychological impairments to functioning in assessing physical or mental status, physicians who are specialists in internal medicine or psychiatry are usually employed to carry out such examinations.

Adults needing protection are usually identified in situations or circumstances and in settings unrelated to the physician's office or the hospital. Individuals with family ties usually have some member of the family who approaches their family physician. Other solitary individuals in confused states found in public places, bus stations, etc. may be referred to a social agency by the police or the Traveler's Aid Society.

As indicated above, physicians are normally brought into the case by the agency social worker or by the Court or may even initiate a protective service on behalf of one of their own patients.

Individuals needing protective services may be grouped for medical purposes as follows:

Group #1. Those persons with physical and mental impairments affecting judgement and interpersonal relationships.

Group #2. Those persons with severe chronic medical problems with disordered behavior.

Group #3. Those persons with severe psychological disorders with severely disturbed behavior.

A physician examining a patient can classify him according to the type and severity of his situation and can make medical recommendations accordingly.

At the present time there is general agreement that a person in need of a protective placement should be placed in the least restrictive alternative. That means that the State, as well as the Court, is more conscious of the need to place as few restrictions upon a person's freedom as possible. There is a feeling that the traditional use of involuntary commitment to a closed institutional setting (a State mental hospital, for example), may not be in the client's best interest if a less restrictive placement would do. The medical community is placed in the position of suggesting a care and treatment strategy which will protect the patient in the least restrictive environment consistent with his impairment. This medical treatment strategy must be a part of the overall planning which also has to take into consideration the social and legal factors as well since all three factors play a part in the plan for the client's welfare.

It is this need to coordinate the three aspects—social, medical and legal—that is the most difficult part of the social worker's development of the case plan. The absence of this coordination, equally, may be responsible for an ineffective solution to the client's problem. Joint planning on a peer level by the physician or the lawyer with the social caseworker is indicated, for successful and effective outcomes.

Some important functions of medical services to adults needing protection include:

1. Making medical diagnosis of individuals referred for protection, spelling out treatment strategies, alternatives, prognosis, predictable risks and probable outcomes. Integrating with social diagnosis and legal recommendations.
2. Serving as medical consultants to clinical social workers in private practice and to social agencies, public and private. Interpreting medical ethics and policies, describing various disease entities and implications and making medical recommendations on cases evaluated on request.
3. Providing medical evaluations, based on medical examinations, on Court clients and wards with respect to commitment and guardianship proceedings.
4. In cases of suspected abuse, making an examination and giving a medical opinion of the nature, cause and extent of abuse. Providing necessary treatment. Giving evidence in Court as required by law.

Social Care Domiciles

Care and protection apart from the medical system usually is found in local community settings, furnished by proprietors

of board and care facilities. States in their policies on Adult Protective Service have put little emphasis on the place of non-medical domiciliary institutions in the continuum of services and care. Any regulations governing health, safety sanitation and civil rights of residents in such establishments will probably be found elsewhere, not in standards governing Adult Protective Service. However the need for a protective setting which is safe, secure and sanitary at least and which is available without resort to legal procedures or a medical prescription is a vital requirement for the protective service agency and with respect to the casework plan.

In protective service practice, particularly in crisis situations, there is often need to find a place for the client to stay temporarily until arrangements can be made for a permanent placement. The board and room establishment, as one of the many types of domiciliary care facilities, may serve in the short term. Long term planning may suggest a similar or different solution.

The advantage of such a facility lies in that it is usually nearby the client's neighborhood; it is immediately available; it is normally less costly than a nursing home; and does not require elaborate arrangements by the agency to place the client therein.

The domiciliary care institution, characteristically, is small (four or more residents unrelated to the proprietor); it is a social care facility—no nursing care furnished by the proprietor; it is non-sectarian; may or may not be licensed by a State or County authority or by a local ordinance; and it provides no service beyond room and board, casual oversight and minimal personal care if at all.

The facility is usually proprietary in nature and is established as a "for profit" venture. The proprietor may be a person with limited education who uses marginal financing; usually has experience in care based on previous employment, normally as a licensed practical nurse (LPN). Other staff may be present with no previous experience except that of domestic service or short order cook. This is of course characteristic of, the minimal facility. While the issue of compliance with standards is not overlooked, it is not overemphasized by those public agencies using such facilities. Such institutions may range from this minimal type of institutional setting to a "Home for the Aged" with professional staffing, more elaborate care functions, social services, a range of personal care services and with health, safety and sanitary standards.

Such institutions may also be termed "Group Homes" (serving 15 persons or less); shelter care homes, board and care homes, residence homes, institutions for the aged, etc. The common characteristic is that these facilities are non-medical. Some group care facilities are non-profit homes and are sectarian in nature. All such facilities serve a social purpose in that they provide a living arrangement that permits freedom of movement and benign oversight for mostly chronically impaired ambulatory individuals who reside in such settings.

Domiciliary care facilities cater to a wide variety of individuals. Most are placed in such homes by their family or by a public or private social agency, or are referred to such settings by a physician, the visiting nurse, or by other institutional managers. The residents may be of any age but many are older persons. There are individuals who are ambulatory but frail. Individuals who are former patients of mental health or mental retardation institutions are found in such settings. Therefore, it is no surprise that individuals who are physically or mentally impaired and are in need of a protected placement may be lodged in such settings. Frequently individuals who are unable to manage their money although they are capable in other respects are found in such settings. Recent studies by the Social Security Administration indicate that many persons with representative payee (the institutional proprietor) are found in such settings. (See Chapter III Section on Representative Payee.)

There are an estimated 700,000 beds nationwide in approximately 43,000 board and care homes.* Occasional "horror stories" are reported in the press of numbers of persons, including the aged, who perish in fires in such institutions. There appears to be a considerable gap in responsibilities which local authorities are prepared to take to enforce regulations for fire, safety and

sanitation and humane treatment in such facilities. The State/local authorities are responsible for enforcement of regulations in such institutions under State law.**

It is evident then, that adults needing protection over the continuum of living find their way in and out of such facilities. The licensed board and care home may be the only alternative to the acute general hospital in many communities, urban and rural. Such homes are utilized because they are there. If they are without any standards each State needs to develop the means to upgrade standards in such facilities. This may be easier than to deal with unpleasant alternatives such as community outrage when fire strikes and deaths ensue or pressure to remove individuals under the Keys Amendment occurs. This Federal law (P.L. 94-566 Sect. 505d) mandates that States develop standards for non-Medicaid facilities expected to house substantial numbers of SSI recipients. Boarding homes are nearly all non-Medicaid approved.

Because of the high costs of nursing care in Skilled Nursing Facilities considerable interest is being shown at the Federal level in the need to develop an adequate and safe living environment, preferrably the often mentioned "least restrictive environment", for individuals who are ambulatory, though they may be frail or old or chronically ill and with mild mental impairments. An ideal type of facility would combine domiciliary care with professional management and limited social oversight and social services in support, at a cost that people can reasonably afford. Standards for fire safety, health and sanitary standards and protection of civil rights would be present but the requirements might not need to be as strict as those imposed on SNF's. This is an area which is at present under study in the U.S. Department of Health and Human Services.

Such a facility could accomodate individuals who are ambulatory but with chronic physical and mental impairments of a mild nature and would be an ideal temporary and a suitable permanent placement for adults in need of protection. This would be a protective social placement. The degree of physical or mental impairment would be the basis for a placement in such settings and a medical and/or psychiatric assessment, followed up by social therapy, would ensure a basis for placement and continued treatment to ensure that the resident once placed could be assisted to remain in such a setting. (See Medical Aspects of Social Interventions, above.)

Methods of Service

Protective Services to Adults are provided in 36 States by direct service staff of the State/local agency administering Title XX. Fifteen States also secure protective services for adults by purchase from other public service agencies (Community Mental Health Centers, Legal Service Agencies, etc.) and 13 also from private non-profit service agencies. Some States use both methods.

States provided service to 81% of their clients through direct service staff; to 15% of their clients through purchase from other public agencies and to 4% of their clients through purchase from private agencies.* Purchase of Adult Protective Services from other agencies requires that the agency providing this service has a solid legal authority base and the readiness and willingness at all times to provide this service to its clients.

The Use of the Team Approach in Public Protective Service—Integrating the Legal and Social Work Roles

Protective Services for Adults involves multidisciplinary team activity in best achieving the goal of protecting the client from harm and from invasion of his rights to self determination. The efficacy of the team approach in public social service delivery has been demonstrated in practice formally and

*See SSRR Reports—Quarter ending in June, 1978. OHDS, HHS. Tables 7 and 8. Number of States delivering social services by method of service. Quarterly. These figures are averages annualized from quarterly service reports from States.

*Office of the Inspector General. DHHS. Service Delivery Assessment of Boarding homes. Wash. D.C. 1979. Appendix 50 pp.

**See *Appendix O* (South Dakota) for a description of exemplary procedures to be employed in complaint investigations of abused or neglected adults.

informally by States carrying out this service.

The actors on the team differ according to the particular client problem and the scenario for its resolution; however, where the problem involves protection of the client's person or his money there are always present the social worker and the lawyer. These are traditional principals in providing the protective service. The social worker interprets those personal and emotional traits, disabilities, functioning capacities and needs which motivate the client's decisions, behavior and action. When the client is unable to understand, communicate or express them for himself or to exert continued mastery over his affairs, for whatever reason, legal intervention of some sort must be resorted to for his own sake. The lawyer becomes involved to establish in Court the client's incapacities and his own legal authority to act on the client's behalf.

Because their perceived missions are not necessarily related nor based on the same assumptions, caseworkers and lawyers may perceive each other as invaders of the client's rights either to protection of his way of life or of his property. Their working relationships may or may not be harmonious. Working as a team to protect all aspects and share responsibilities for the client's life and welfare is often very much a matter of luck and personalities.

Within the social service area, teamwork is more usual. In many cases, older persons particularly, with multiple needs are found in complex situations and circumstances where a team approach to daily management is indicated. The basic social service team composed of a caseworker, homemaker and case aide have, in State's practice, moved in on a number of situations when older persons are discovered living alone, in debilitated housing, in filthy surroundings, isolated, malnourished, ill and depressed and unable to exercise those capacities of independence, self reliance and decision and choice which we all need to manage our daily lives. Social service teams have demonstrated in actual case situations the capacity to move in, help the client to express his needs, and provide care quickly. At the same time they oversee his psycho-social, emotional and mental strengths and handicaps and judge his capacity to maintain and retain basic skills of daily living. This team working together consistently has assisted him to recognize what he can and cannot do to continue to live in a community setting and when indicated, have arranged for those social supports necessary for adequate nutrition, restoration of mental and physical health, as possible. This team (caseworker, homemaker, case aide) tries to improve his ability to make decisions affecting his continuation of independent living and makes every effort to respect his wishes to choose to live in his own home, the home of a relative or with others in a social group setting, if he can manage with the level of service available.

Where other need is indicated, the caseworker managing the team (and the case) calls on other professional providers—the visiting nurse, the physician, the senior or day care centers, etc. These other providers in a sense then become sometimes unwilling members of a comprehensive service team, not necessarily pursuing coordinated goals or consistent approaches, nor even regular communications. In a protective service system, however, the comprehensive team functioning as a group is built into the procedures. A study of the effects of such a service approach has shown great benefit to the client and has demonstrated that such clients improve at a faster rate than other methods used.*

Where it is evident that the client's ability to manage his finances indefinitely is limited or even lacking because of emotional or mental disorder (such as Alzheimer's Disease) and there is no family to take responsibility and he needs an authorized surrogate, the social service team arranges for still another professional intervenor, the lawyer-consultant. This legal advisor then joins in the larger team approach required in protective service interventions. The lawyer in such a combination adds his perspective to service interventions, each profession contributing its special knowledge and skills. Total integration of the multidisciplined effort is needed when older persons are found in such circumstances.

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*See DHEW Publication No. (SRS) 72-23008, Protective Service Project for Older Adults.

Such a process, however, is not usual. Lawyers, traditionally representing the client's interest in Court are often in conflict with the lawyers presenting the State Protective Service request for legal intervention to protect the client's money or their person. Thus, each attorney attempts to protect the client from the other.

In the protective service system, this traditional separation of law and casework procedures is broken down. The legal advisor's role also changes and broadens as he loses his independent role, so that he can join, incorporate and represent a balanced, broad team understanding of the client's need for self direction or services, and can protect his property rights more adequately along with his rights to protection of his person and his personal identity. In joining the team he can contribute to their group decision his special knowledge. Thus the advocacy role also is maintained while he can affect and be affected by the other responsible professionals involved. Separation by way of civil rights versus human management needs—lawyer versus social service—is thus eliminated. The lawyer then represents in Court not only his client but his human management—protective service—team without conflict. The Court is thus aided in its determination by a broader more considered viewpoint about the client's competency and legal protection, on which it can have gratifying confidence.

If the legal profession would explore setting up such a program and studying its significance they might benefit the entire protective service system.

In a team service system, the social work case manager is usually in the best position to bring together these professional resources in a sequential and a concerted way to coordinate, integrate and accomplish a common case plan.

Although the idea of case management and the team concept may be simply put it is obvious that such concerted action is only achieved by a professionally sophisticated social caseworker who is knowledgeable about the social therapies and the psycho-social needs of adults, as well as each of the several disciplines—law, medicine, nursing, psychiatry, etc; their knowledge base, their values, and the limitations involved in their utilization by caseworkers. In addition to proficiency in their own direct service role, the need to know specialist community resources and to quickly call them into play is absolutely necessary. Such resources include, but are not limited to: temporary shelter, emergency room availability, arrangements for visiting nurses, the internist knowledgeable about and practicing geriatric medicine; the psychiatrist specializing in problems of adults and the aged with mental problems, the lawyer familiar with the Court and law enforcement generally, the availability of such services as homemaker, chore, meals; a working arrangement with the police when authority to effect legal entry when the confused or frightened client refuses entry—all of these resources must be known, understood, and how to arrange to secure immediate use of them.

The team approach assumes that all of the major and subsidiary participants in the protective service are highly trained to assure that leadership, continuity and professional judgement and public responsibility are present and effectively provided. Good will and the neighborliness stressed in the literature, or the use of incompetent or unknowledgeable workers, cannot assure the leadership and continuity which are needed to do the job, in the complicated bureaucracy which exists today in both the public and private sector of our society. The team approach is ultimately dependent upon a mutual respect and joint commitment, upon knowledge and skill and in an educated capacity to work in meaningful interactions to accomplish agreed-upon goals. Therefore, professional training must be stressed. When volunteers are used they should become qualified to contribute not only to the client but to the team effort and they should be supervised by an appropriate professional. Protective Service for Adults cannot work without trained staff.

Because of the lawyer's special position as well as his knowledge, he can contribute an otherwise arcane understanding of how legal protection works to the professional team, and thus can add a training component to the other members which reduce blunders or ill-

advised actions which delay necessary actions on the client's behalf.

Protective Service, in practice, in the team concept, relies on interlacing networks, each a system in itself, to provide the resources to deal with the multiplicity of problems and needs of individuals. To get this to work requires someone familiar enough with all of the networks and how to plug in on them, and with the patience, fortitude and persistence necessary to achieve harmonious interaction of the parts. This is the contribution of the professional social work-case manager.

Social Guardianship

Social Guardianship is the provision of a continuing direct protective relationship to an impaired person by a social work case manager for purposes of understanding the wishes of the individual and his emotional needs, and to provide the reassurance that such a person needs, which can best be provided through such a protective interpersonal relationship. Since such a function requires highly skilled professional training, the reader is urged to review in its entirety the reference on "The Public Agency as the Social Guardian" by Helen Turner, to be found in the bibliography.

Crisis Intervention and Emergency Services

Throughout this document it is assumed that adult protective services are provided in situations and circumstances where probable or actual harm may occur if social and/or legal interventions are not quickly initiated and carried out by the agency.

Hawaii points out that a protective crisis is present when the Department is made aware of an adult experiencing extreme hardship because he is unable to protect his own interest and cannot or will not act on his own behalf, or fails to get a friend, spouse, relative or other interested persons to offer the necessary protection and care needed.

The State agency limits the protective crisis situation to a period of no more than 90 calendar days from the date of referral to the agency, with provision for extending the period to 180 days if legal intervention is initiated.[17]

The State of Washington outlines circumstances which may require crisis intervention where the goal of the worker is to help the client to resolve this crisis. Their outline may be helpful to the reader to review.[18]

The State of Kansas expects its service staff to introduce needed services in crisis situations (when family and/or significant others are non-existent or unable to intervene) taking the client's agreement for granted unless there is marked opposition. In crisis situations, it is sometimes necessary for social workers to assume command and impose needed services because the client has become immobilized, unable to think things through or act and has has no one to act in his/her behalf. If the client resists, there is little the social worker can do.[19]

In such emergency, health service necessary to maintain life or to prevent irreparable harm in Alaska will be secured by the caseworker acting on behalf of the client.[20] The social worker is expected to exercise judgement in all emergency situations If the adult possesses the capacity to understand and be aware of the emergency situation and refuses to give consent, emergency services will not be provided.[21]

The emergency nature of protective service is emphasized throughout this document. An accident in the home, an automobile accident, sudden loss of a spouse, can trigger an emergency. To overcome irresolution and panic in crisis the protective service worker has several tasks. Defining when a situation is considered a crisis is one task; another, obtaining voluntary agreement to a course of action; the third, intervening effectively within time limits necessary to avoid potential danger to the client's welfare.

The crisis phase of social intervention in most States is time limited. This has at least the effect of forcing decision on the part of the client and his family to accept recommended services and on the part of the agency to develop and implement a case plan.

It may have an unintended consequence. If not resolved, no help.

Representative Payee

A representative payee is a person appointed by the District Office of the Social Security Administration to control the use of a beneficiary's social security payments (similar to protected payments in Public Welfare).

A representative payee is required when the adult is unable to manage his money. He must be receiving social security benefits (OASI - OASDI or SSI benefits) to qualify.

A consistent pattern of irrational behavior is the best indication of a need for a representative payee. Individuals may hide money and later be unable to locate it, or they may lose or destroy assistance checks, or may not pay bills resulting in the utilities being cut off, or not properly budget their funds so that by the middle of the month they have no money until the next check is received.

The Social Security Administration is empowered to appoint a representative payee to control the use of funds of the beneficiary who is unable to manage his check. Usually a family member, a friend or other responsible and reliable person is sought to act as a representative payee. There is no renumeration provided. Duties and responsibilities of the representative payee are established by the Social Security Administration which oversees this program.

It appears that a number of aged, blind and disabled SSI recipients in boarding homes have a representative payee because they were deemed incapable by the Social Security Administration of managing their own funds.[21a] There are no statistics available to this writer on how many SSI recipients in boarding homes had a representative payee.

See Appendix I for one State's (New York) guidance to staff on representative payee responsibilities and how to secure them.

Central Registry

There has been in only a few States a commendable movement to develop a central register of Adult Protective Service cases. This central register maintains data which is available to staff in the State agency. Several illustrations follow.

The State of Kentucky maintains a statewide Adult Protection Central Register. The purpose of the central register is:

(1) to gather and disseminate data on the incidence and characteristics of adult protective services.

(2) to serve as a resource to field staff in defining problem areas, training and policy development; and

(3) to identify reported perpetrators, in particular, caretaker operators.[22a]

Arizona, which maintains a similar system, makes clear that this file is confidential.[22b]

Kansas clearly states that the reports of abuse, neglect and exploitation of adults are to be appropriately prepared and well documented when sent to the Central Registry which is maintained by their Adult Services section.[22c]

Washington maintains a central registry of mentally retarded adults. This central registry is a system of centralized storage and retrieval of case information of all substantiated instances of death, physical injury, physical neglect, sexual abuse or mental injury of a mentally retarded person... This information will be available to requesting prosecuting attorneys and others who legitimately require it.[22d]

The issue of confidentiality in the use of Central Registries is unanswered. How it should be protected and divulged to properly delegated agencies are important considerations.

Service Outcomes

The purpose of service programs ultimately is to protect the client. The various services available are identified in each State's service plan. The action of the case manager to quickly develop a plan of service and implement it, in crisis situations, will obviously affect the outcome.

A few states have developed thoughtful materials on how to gauge successful programs.

Washington State has outlined planned

program results as follows:

The crisis situation controlled:

(1) client is no longer being abused

(2) client is no longer being neglected

(3) client has been removed from an extremely hazardous environment

(4) remedial medical care or mental health services have been arranged for and provided.

Protection provided:

(1) the client has been removed from the situation in which he/she suffered abuse, neglect or exploitation

(2) the client's fiscal resources have been protected

(3) the client has moved to better housing and the problem has been resolved

(4) homemaker, chore services or both have been provided to correct unsafe or unsanitary conditions

(5) necessary home repairs have been achieved and the premises are no longer unsafe or a health hazard

(6) protective payment, representative payment or guardianship has been established.

Rehabilitation achieved: The client has been placed in a medical, psychiatric or other domiciliary institution for the purpose of achieving physical or mental rehabilitation.

The service plan fails.

(1) the client is unresponsive and cannot be encouraged to cooperate

(2) interference of relatives, friends and others in the plan of service for the client cannot be overcome

(3) the community lacks the necessary resources to bring needed services to the client and no suitable alternatives have been found to remedy the situation.[23]

The State of New York has identified expected service outcomes graphically. See Appendix S—Flow Chart in Protective Service Process.

In protective services provided to adults in the large States, public social service programs obviously have a wide range of outcomes. Factors (both positive and negative) which are influential in determining service results include the client himself and his willingness and ability to go along with the service plan; skilled, knowledgeable case managers and caseworkers; a dearth of resources which are readily available to meet the needs of clients for shelter, employment, care or reassurance; inexperience of casework staff in offering help to the client; and the client's inability to make full utilization of the assistance offered.

The absence of alternative independent community living arrangements for those individuals who could still manage if protective placements with limited benign oversight were offered is a contributing factor to the success of service. Also, the need for individuals willing and able to serve as "committees" or "conservators" or even "guardians" with limited responsibilities for money management is profound. Their absence affects how well the client is served. Indeed, one might say that lack of these services makes a so-called "service program" a misnomer; and the results instead of referred to as "service outcome" should be dubbed "no service outcome".

Because of the potential for legal intervention service managers may eschew the use of social interventions. Legal authority has it all over persuasion, particularly when service staff faced with high caseloads and lack of available alternative resources have to do the "persuading." The Probate Court can order the client institutionalized. Compared to social intervention this is a quick fix. However, the need for the same facilities, the same oversight methods and the same support services is there in each instance. Institutionalization thus is a disposition, not a solution.

Courts recently have ordered States, without particular success, to "protect" individuals particularly those discharged from mental institutions. If resources do not exist, the Court is no more successful than anyone else in creating them.

There is no substitute for the difficult task of a case service manager in developing a realistic protective case plan on the basis of a realistic assessment of the individual's capacity to manage his money or his person or his life in today's community. Once the

service plan is developed, the task of carrying it out depends on in-depth knowledge of the community and its resources, plus the ability of the service manager to seek out and, with determination and self confidence, to secure the particular resources needed to meet the goal of the case plan. As was enunciated above (See "Case Management") the case manager/caseworker is key in a successful case outcome.

Transitional activities

Nebraska outlines the process involved in arranging for legal services as follows: When the service worker concludes that it is necessary to legally intervene to protect the client from harm or threatened harm due to action or inactions by another individual or through the client's own action, the service worker shall:

1. Contact the county attorney to report such abuse/neglect.
2. Request the county attorney to file a petition for mental health commitment or other protective proceeding, when appropriate, or request that an attorney interested in the well-being of the client file a petition for guardianship or conservationship, when appropriate.
3. Submit a written report detailing the findings of the investigation and needs assessment to the county attorney or other attorney interested in the well-being of the client. The worker shall include:
   (a) a summary of the client's current situation including the reason the client appears to be neglected/abused and the reason the client needs guardianship, conservatorship or mental health commitment.
   (b) the service unit's efforts to provide services and the client's and/or guardian's (if any) response to these efforts.
   (c) living arrangements
   (d) income and resources
   (e) recommendations and tentative plan for the adult.
4. Continue to monitor the client's situation until the county attorney or other attorney interested in the well-being of client files a petition or takes other action to protect the client. If the county attorney does not file a petition or take other action within 60 days, the service worker shall obtain the client's or the guardian's signature on form DSS-3A if protective services are to continue.

Protective Services may not be provided beyond 60 days without acceptance of services by the client or the client's guardian unless court action has been initiated within the 60-day period.

The service worker will continue to monitor the adult's situation until the county attorney files the petition or takes other action to protect the adult, as the decision is made, for whatever reason, not to take physical action.

In all judicial hearings, the social worker shall provide such testimony as required by the court, the county attorney, and the client's attorney.

When the service worker determines that the client may need legal services other than protective legal proceedings, the service worker shall refer the client to an appropriate source of legal assistance, e.g., legal services under Title III Older Americans Act; a legal aid society, the Nebraska Bar Association or the county attorney.[24]

One State, Texas, identified the legal aspects of protective services as including the following actions:

1. Those actions which involve the readiness to use legal authority and procedures on behalf of an adult who cannot manage his/her money, or is exploited or is in danger; or
2. Which involve court action to determine whether the adult is incapable of managing his/her property or affairs, and which may result in the establishment of some form of legal trust relationship, such as guardianship, or commitment to an institution for such an individual.[25]

Other States limit adult protective services mainly to social interventions and where the use of legal authority or legal services or legal actions to protect the individual are necessary refer all situations to law enforcement authorities.

Legal Interventions

This section will consider the differences in concept of the legal base for overall protective services programs in States, and differences in limitations imposed by States on legal action.

Moving from social interventions to legal interventions is to move from the social agency to the province of the Court and the law enforcement authorities, and to use of members of the legal profession to provide or arrange for legal protective services.*

The social casework relationship with the client remains. However, a new relationship between the agency, the family, client and the Probate Court and other legal authorities is formed. This new relationship is especially grave in its implications for forcing abridgement of the individual's control of his money and, indeed, of his own person.

The Introduction to this Chapter discusses the characteristics of a Protective Service and the potential for the use of legal authority.

The Fiduciary Relationship

The new relationship, for legally competent individuals and those carrying out legal action for their protection, is a fiduciary or trust relationship. The individual permits a greater or lesser degree of control over his estate (money) or person to be assumed by someone else. That individual may do so on the basis of a voluntary action or agreement, or it may be done involuntarily if the individual is adjudged by competent authority (the Court) on the basis of evidence (usually medical) to be incompetent by reason of mental disability or dysfunction.

There are several ways of managing money, which are considered later in this section. The principal devices used are power of attorney, guardianship and conservatorship. The representative payee, described under social intervention in a previous section, is another method of managing the money of a public assistance client. Guardianship of the estate (the money) is also used.

There are a number of ways of protecting the person by legal means. Guardianship, that is management of the person and/or his estate, is a principal legal procedure for protection of an adult who is adjudged by the court as incompetent. Guardianship may be temporary or permanent depending upon the purpose of the Court in imposing it on the client. It will be considered further below.

Other devices or procedures are the use, in some States, of a "Committee;" legal protective placement, temporary or permanent; and by commitment to a mental institution. A legal procedure is required to determine incompetency. It is defined as an incompetency proceeding.* The Court uses specific tests to determine incompetency.

All of these legal devices or procedures are hallowed in the laws of this country and under the English Common Law. These devices have the effect, particularly as they affect the incompetent, of curtailing their civil rights as long as the ruling or procedure is in force. There is also the question of consent. The individual, if he is mentally competent and refuses his consent, should not be forced into accepting guardianship, hospitalization or placement in a nursing home. Even mentally competent individuals who do not wish to do so are vulnerable to such pressures.* See Chapters III and V for references to tests of competency to consent to treatment.

States, in their statutes dealing with Adult Protective Services, attempt use of suitable legal devices and procedures which respect the individual's rights and the need for protection. What comes through in most States service manuals is the principal caution not to move hastily into the use of the legal process for protection of adults until all available social interventions have been exhausted. See Table III - APS laws. (Appendix)

It is important to become familiar with legal procedures, how they operate, advantages and disadvantages and costs associated with their use, both for the agency and the client.

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*See Appendix U. Question 10.

*See Appendix R for a standard to measure incompetency through functional classification.

*See article on the Legal Dimensions to Protective Services for the Elderly by John J. Regan, Professor of Law, University of Maryland, Baltimore, Md. Prepared for the National Conference on Social Welfare meeting, Washington, DC. June 15, 1976, for a fuller discussion of the issues around the use of these legal procedures.

The Court System

The Probate Court is normally the court of competent jurisdiction for these legal instruments. The probate court judge is the person who determines, on basis of the evidence, what is best for the impaired client. It is through the Probate Court system that the legal procedures which can protect the clients' best interests are delivered and due process protections are assured.

In Probate Court actions, most States and the courts insist on an attorney to represent the client in any action brought by a protective agency or agent which may result in the client losing basic rights or vesting the control of his money or person in someone else. The development of the public defender, the ombudsman movement (for oversight of long term placement and care particularly of the elderly in an institution) and legal advocacy agencies in the last decade have all addressed the issue. Abuses in carrying out legal interventions have been found. Older persons, particularly those with valuable property, have been "railroaded" into institutions by unscrupulous relatives or by other means and precious freedoms have been lost. Clients' rights to consent to certain actions has been ignored in Court hearings and guardianship. It is for these reasons that the State in the use of any or all of the legal interventions described below should move carefully to protect a client's rights when they protect his person and his estate.

Commitment for care and services to an institutional setting for an incompetent adult is a legal procedure which States have used since the beginning of the Republic. Institutional commitment for adults determined by the Court as incompetents became one means of "protected institutional placement."

One abridgement of civil rights comes to mind.

Over the years States developed a network of mental hospitals and institutions for the mentally retarded as part of their mental health system. For the last decade and a half, however, adults have been discharged from such institutions to skilled nursing homes, intermediate care facilities and other group living arrangements. Legal responsibilities for care, particularly in the mental health system, continue to reside in the State Mental Hospital Administration as patients "in remission" were discharged to community settings without restoration of civil rights. This device permitted quick re-entry into the State mental hospitals for those individuals discharged from State mental hospitals who were unable to adjust to the stresses of an open community life and who were considered a menace to the community to which they were sent. However, not all dischargees were able to remain in the community.

While in remission, civil rights (i.e., to vote, to marry, to contract) were abridged in numerous cases. Thus individuals were "free" but really not free. Commitment, then, is one legal procedure which deserves serious scrutiny. On one hand "protective placement" is offered "incapacitated adults." On the other, release, as we shall see, is not as easy as entry.

Yet the legal procedures described below are the only ones available for the protection of incompetent persons or those who voluntarily apply for protective placement.

Legal Base

The legal base for Adult Protective Services at the Federal level is the Purpose Clause of Title XX of the Social Security Act, "Preventing or remedying neglect, abuse or exploitation of adults unable to protect their own interests." (Section 2001, Title XX, Social Security Act).

States refer in their service manuals to the State statute on which legal authority to carry out Adult Protective Services is based. These include: South Carolina, Arkansas, Iowa, Arizona, Colorado, Nebraska, New York, Alabama, and Kentucky.

Table III of the Appendix lists State laws on Adult Protective Services.

State laws on Adult Protective Services cover the following topics:

(1) The designation of the agency charged with the delivering the service and scope of authority.

(2) The complaint procedure where

there is neglect/abuse or exploitation or other reason for intervention.

(3) Procedures authorized for emergency intervention.

The States differ in their interpretation or emphasis of these areas.

South Carolina's Adult Protective Service law is designed to establish protective services and assure their availability to all persons when in need of them and to place the least possible restrictions on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, exploitation and neglect.[25]

Arkansas in its Adult Protective Services Act as amended, emphasizes protective services to the developmentally disabled.[26]

Alabama in its Adult Protective Services Act of 1976 emphasizes mental impairment and mental incapability on the part of the individual in need of protective service and his inability to protect himself from abuse, neglect or exploitation by others.[26]

If there is no specific legal authority then States use other available means. Texas does not appear to have a specific statute covering adult protective services (as of September 1979). Although specific legislation was proposed it did not pass the legislature. Consequently, services to adults in this State are limited to those social interventions which are common in social service practice in that State. Any legal protective intervention is limited to guardianship or commitment procedures already established under the State law.

The State of Louisiana, for example, uses the Title XX law. Its Annual Comprehensive State Plan outlines the State's intent to provide services to those adults who are harmed or threatened with harm and unable to protect their own interests.

Restrictions on workers' activities, in the absence of a legal base, are outlined in the Louisiana service manual as follows: The service worker cannot: enter the individual's home against his will and without his permission; remain in the home after the individual, a member of the family, or a person entitled to make such a request has asked the worker to leave the premises; provide social services when the individual has stated he does not want services; look through the personal possessions of the individual without his permission; remove the individual against his will from his or her living quarters to another living environment; take direct action to commit an individual to a mental institution; arrange for an individual's admission to a hospital or nursing home against his will; manage an individual's money or property; direct the individual's actions against his will or permission; take direct action in judicial commitments, coroner's commitments, or emergency commitments; and discuss case situations which violate confidentiality.[27]

Although there is no law authorizing the West Virginia Department of Welfare to provide Adult Protective Services, there is a mandate in the State code (Ch 9, Art 2,5,6) directing the Commissioner of Welfare to formulate any regulations and implement any program he deems necessary for the benefit of the citizens of the State so long as it is not inconsistent with already existing State codes. The Department of Welfare uses this authority, pending specific legislation, to carry out adult protective services. Allowing for the protection of individuals' rights under the 14th Amendment of the U.S. Constitution, if the State is to intervene in an individual's life it must have good reason, i.e., a documented, valid, reason. Draft material dated September 1979 for adult protective services developed by the State of West Virginia outlines examples of such reasons; including abuse, eviction, mental dysfunction and inability to handle money.[28*]

Some States, like Connecticut, limit their Adult Protective Service law only to the elderly. The Connecticut law results in the need for two separate and different legal bases for the provision of protective service to adults and requires two separate State Agencies to be responsible for administering, from the managerial viewpoint, Adult

*This draft material has been incorporated in the State's Service Manual as of this writing as permanent policy material. (S. 29100 H.)

Protective Service programs. This appears redundant. Actually, however, the two agencies' programs are directed to different specialized needs.

Connecticut requires the regional ombudsman to investigate cases of abuse in nursing homes before referring those it determines in need of protective servics to the Commissioner of Social Services for provision of protective service (Sect. 4 of the Connecticut law). This separation of investigation and service provision is duplicative and appears to some to be too cumbersome for prompt response to emergency and crisis situations.[28]

State Agency agreements which permit joint planning and action by each agency so that each can assume its responsibilities without a duplication of effort, it is argued, would be a better way than to split responsibility as in the Connecticut experience.

The legal jurisdictions of a protective service for adults can range from the most general directions to the most specific State statutes. As indicated in the West Virginia example, a State has utilized a broad legal authority to give the Welfare Commissioner authority to carry out this service; but even in such a situation, valid documented reasons for interfering in clients' rights to be left alone are required. Louisiana has felt obliged to establish the limitations placed on workers which prevent them from directly interfering with the client under very specific circumstances.

Without a State Adult Protective Services law, State Agencies have uncertain authority and responsibility to investigate and to intervene in adult protection situations. Also, in life-threatening situations it may not be clearly understood in communities that the State/local Agency administering the public social service programs has a responsibility to seek legal intervention unless this reponsibility is clearly a part of the Agencies' legal base.

A handbook of Model State Statutes covering Adult Protective Services was published by the National Council of Senior Citizens, Washington, D.C. The research, sponsored by the U.S. Office of Economic Opportunity, (now Community Services Administration) was completed in 1971 and was developed under the auspice of the Legislative Research Center of the University of Michigan Law School. The model statutes relate to Public Guardian, Guardianship and Conservatorship, Power of Attorney, and Local Protective and Supportive Service Systems. This handbook would be a good source of information for States wishing to review their own statutes.

There is little offered in States to give legal sanction to private voluntary agencies to act in a surrogate capacity as organizations for protective purposes. Further, most Family Service Agencies appear to be unwilling to act as guardians or conservators. Their registration as social agencies licensed by the Secretary of State in most States, usually does not include this responsibility. However, there is good reason to believe that they can act as a protective service agency in a surrogate role with their agency staff carrying out agency policies when this responsibility is stated in the agency's By-Laws.

As we see, there are some drawbacks to the use of legal interventions. They are narrow in their application; sometimes unsuitable for quick action; and may have a tendency to violate the civil rights of individuals to whom they are applied. Over the years some States have developed modifications, such as temporary guardianship and emergency placement, so as to be more responsive to a need for quick actions to protect the individual from further harm.

States may wish to consider utilizing licensed private social agencies on a volunteer or contractual basis to carry out social guardianship functions. The private agency caseworker, furthermore, represents the client, and not the public agency interest as well, which is the dilemma of the public protective service worker. Other issues on the use of voluntary agency workers are mentioned later in the section on conservatorship.

The Lawyer and the Social Worker

Protective Service for Adults involves lawyers and social workers in a symbiotic relationship, which is to be nurtured as it is a delicate and fragile relationship.

There are problems in the way lawyers relate to clients and to social workers dealing with the same clients. Although both professions establish a "trust relationship" with the client it seems difficult for each of these professions to understand and to accept each other's methods (adversary relationship—helping relationship) to achieve protection. However, protective service serves as a bridge to connect these two professions when both professions work together to achieve the common goals of protection. Otherwise, wariness and suspicion too often characterize the attitudes of representatives of both professions toward each other. These attitudes are barriers to effective protective service delivery.

The team relationship described under Methods of Service in this chapter suggests ways in which lawyers and social workers can collaborate to develop effective social and legal interventions in protective service actions.

Social service workers on the staff of County Departments of Social Service turn to legal interventions when such interventions can best serve the agency's plans for the client. In doing so the service worker works closely with law enforcement officials, like the police, in gaining entry on the basis of a Court order; with the Probate Judge, in securing a protective placement and with lawyers in helping clients gain entitlements; with arranging preparation of wills and with numerous other problems which can best be solved by legal interventions. The public service worker can succeed in accomplishing his job by developing good working relationships with these resources. Administrators and managers of Public Service agencies must be aware of, and take responsibility for, facilitating such relationships.[28]

Some specific legal procedures used to protect clients' money or person or to carry out a surrogate function are outlined below.

Power of Attorney

"Power of Attorney" is defined as a document or legal instrument authorizing another to act as one's agent or substitute. Essentially it is an agreement between two persons where one person takes responsibility of representing another party and his rights and interests. The adult can delegate as much or as little power as desired. Power of Attorney can be revoked at will at any time and is terminated at the death of the person who originally gives the power of attorney. It can be used, conveniently, by a person who is immobilized and needs to transact business. The client is assumed to be competent at the time he gave the power of attorney and if there is any question and a court of competent jurisdiction finds that the client was incompetent at the time he/she gave power of attorney, the power of attorney will normally be terminated. All actions transacted under the power of attorney can be declared null and void. Caution should be exercised when suggesting this course of action to a client because the power of attorney ceases if the individual becomes incompetent, thus it is worthless at the very time it would be most useful.[29*]

Conservatorship

Conservatorship is a trust relationship in the broadest sense created when one person is entrusted by court order with the management of the financial assets of another person (or of his person). A conservatorship is normally requested when the person's physical or mental health is such that he or she cannot care for, conserve, nor properly use any property, real or personal, which he or she may own.

Also, a petition for the appointment of a conservator of the property of an adult may be sought to protect the property of an adult if the protective concern is based on an imminent danger to that person's property.

A conservatorship may be established if the adult is unable to effectively manage his/her own financial affairs because of physical or mental illness, excessive use of alcohol or drugs, confinement, lack of discretion in

*Illinois has established a new law on "durational power of attorney." This extends power of attorney in instances where competent people become incompetent through natural aging.

managing benefits received from public funds, and has property which is necessary to provide support for the person or which would be mismanaged.

The most common problems necessitating consevatorships are related to:

(1) liquidation of personal property (stocks, bonds, notes, etc.),

(2) payment, delivery, deposit or retention of funds or property,

(3) utilization of real property by sale or rental,

(4) control of money and resources.

At this point it is necessary to make a distinction between the need for assistance with financial management and the need for care and supervision. An individual may have need for one without the other and a finding for one sort of help should not automatically determine the need for help in all areas. This is explained by the fact that the adult is deemed competent in all areas but limited in ability to handle his money, which may be due to the reasons alluded to in the preceeding paragraphs.[30]

The Mental Hygiene Law, Art. 77 of the State of New York, for example, sets forth the procedures for the designation of a conservator of the property for a resident who has not been judically declared incompetent and who, by reasons of advanced age, illness, infirmity, mental weakness, intemperance, addiction to drugs or other cause is unable to provide for himself. The law provides that a proceeding for the appointment of a conservator may be commenced by "a friend" including a corporate body, a public agency or a social service official of the place where the conservator resides, regardless of whether a recipient of public assistance. A social service official may be appointed as a conservator. The conservatorship does not carry the stigma of a declaration of incompetency.

The petition for conservatorship is usually brought in the Supreme Court or County Court for the district in which the adult lives.

If the Court appoints the local Department of Social Service Director as conservator then the necessary protective services will be provided under the State's policy related to Adult Protective Service. If the Probate Court appoints an individual, agency or organization other than the Director, DSS, to be a conservator for the adult, then the Director, DSS, will make suitable arrangement with the conservator for the delivery of services provided for in the policy. If the conservator refuses to allow the delivery of services, the Director, DSS, will petition the Probate Court which appoints the conservator for the removal of the conservator for cause shown. Whenever the Director, DSS, is designated to act as conservator for cause shown he may delegate the performance of such duties in accordance with the State statute.

Some States allow for the appointment of a temporary conservator in the event that immediate action to secure a conservator is required to prevent harm to the person's property, and the regular appointment of a conservator will take too long.

Kansas permits the individual himself to make a voluntary application for the appointment of a conservator. In this way a person can have a conservator appointed to make financial decisions for him without being determined an "incapacitated person," thus not losing the right to make personal decisions. Revocation can occur at any time the person who made the petition for a conservator wishes to do so.

Conservators are usually given only those powers necessary to supply the needs of the protected person. The conservatee does not lose any of his/her civil rights and the appointment of a conservator is not evidence of the incompetency of the conservatee.

The selection of a conservator must be made with the adult's participation and consent.[31]

An interesting discussion of the role of the Social Service Agency as a conservator and the issues it raises for the Agency may be found in an article in the Journal of Gerontological Social Work, entitled "Conservatorship—a Move Toward a More Personalized Protective Service", by Barbara Schoenfeld and Teresa Jordan Turzil, MSW.[31] This article deals with the implementation of the New York State Conservatorship law (Art. 77, Mental

Hygiene law) by a private voluntary social work agency and issues arising from it around confidentiality, self determination and areas of possible abuse.

Guardianship

"A guardian is a person lawfully invested with the power, and charged with the duty, of taking care of a person; in managing the property and rights of a person who, for some peculiarity of status or defect of age, understanding or self control, is considered incapable of administering his or her own affairs."* The concept of guardianship is derived from the legal powers and duties inherent in a parent and child relationship. It is based on the English Common Law doctrine—"Parens Patriae." Guardianship is a protective legal instrument or device for protecting legally incompetent and incapacitated (as defined in State laws) persons.

Guardianship may be directed to protection of the person of the incompetent or incapacitated adult (as defined in State statutes) or to protection of his/her estate. The problems connected with money management and the problems connected with the provision of care and supervision are quite different. It is important to recognize this because the guardian has such absolute power over the incompetent's estate or his person. Caution should be exercised in using this legal device since it is susceptible to great abuse in unscrupulous hands.

Some States have individual statutes covering Adult Protective Services. The statutes cover guardianship definitions and procedures. Each State's statute is unique. The Uniform Probate Code has developed model State statutes covering guardianship. The Office of the State's Attorney General appears to be a basic resource for States which do not have statutes covering Adult Protective Services, to help them to develop one.

Because of the complexities of the law on guardianship, this section will only deal with general principles enunciated by States with respect to guardianship.

The decision to ask for guardianship is seen as a last resort, soundly based on evidence that the client is unable to manage for himself, even with the help of preventive and supportive services available directly or indirectly from the State agency administering the adult protective service program.

Someone must apply for guardianship of an incompetent or mentally retarded person. In New York State, for example, there is a distinction between guardianship for the mentally retarded and committees for the mentally incompetent.[32a] Guardianship is usually undertaken by the Court on the basis of "certification of incompetency by competent licensed medical practitioners." They may be physicians in general practice, internists, or psychiatrists. Some States use teams to determine if an adult is legally "incompetent." A licensed psychologist, psychiatric social worker or nurse is part of the team that certifies incompetency. Any person may file with the court a verified petition for the appointment of a guardian. The Court may appoint a guardian if the allegations of the petition as to the status of the proposed ward (i.e., that the proposed ward is incapable of caring for his own person and that his best interests require the appointment of a guardian) and the necessity for the appointment of the guardian are proved.

Some States distinguish among the types of individuals needing guardianship. Kansas, for example, states that guardianship is the broadest and most comprehensive instrument for control since it transfers total transaction power to the guardian as a substitute decision-maker. Mentally retarded adults are felt to be capable of making some decisions concerning their welfare and are capable of making other decisions with advice and with the provision of social services. This argues against guardianship as a suitable procedure for some mentally retarded adults and suggests that an assessment and evaluation should be made of the mentally retarded adult before any decision to use guardianship is finalized in this state.

State statutes indicate some differences in

*Blacks Law Dictionary, Rev. 4th Ed. p. 834

whether guardianship should be established through social service departments or legal departments.

Most States incorporate consideration of guardianship as a legal protective resource in their policy manuals. This is done as part of crisis intervention for purposes of protection. Emergency situations usually trigger protective actions by States for adults.[32b]

Virginia, in providing for involuntary protective services for an individual deemed to lack the capacity to consent to receive protective services uses an emergency order or accomplishes the purpose through the appointment of a guardian. The Court is bound to authorize only that intervention which it finds to be least restrictive of the adult's liberty and rights while consistent with his welfare and safety. The adult is not required to pay for involuntary protective services unless such payment is authorized by the Court upon showing that the person is financially able to pay.

In issuing such an emergency order, the State of Virginia requires the Court to adhere to the following limitations: only such protective services as are necessary to correct the condition creating the emergency and specifically finding whether hospitalization or a change of residence is necessary. The order shall be valid only for 5 days with provision for one renewal period of 5 days (10 days in all). The Court will appoint a temporary guardian of the adult (guardian ad litem) with the responsibility for the person's welfare and authority to give consent for the person for the approved protective services until the expiration of the order. At the end of the period, if the situation is not resolved, the temporary guardian or the local department of welfare/social services shall immediately petition the Court to appoint a guardian pursuant to S 37.1 - 128.1 or 37.1 - 132 of the Code of Virginia.

Many States operate similarly to the State of Virginia. In some States temporary guardians may function up to 6 months.

At least two States in their policy on Adult Protective Service do not permit a social worker to assume guardianship of a client (Arizona and New Mexico). Another State, Colorado, permits the Division of Protective Services in the State Department of Public Welfare to act as a guardian for the mentally retarded. Contrary to Kansas opinion (above) Colorado feels that guardianship may not be suitable for frail older persons but may be suitable for severely retarded adults. But even in such instances as noted above, the control exercised by the guardian might be limited to a specific duty—protection of specific property rather than total authority over the person and his/her estate.

One State, Georgia, outlines the type of client situations which might result in a voluntary request for protective services such as: a person reports that a family member keeps him confined and does not provide a proper diet; or a person reports that a family member or neighbor cashes his SSI checks and spends the money on himself; or a person who is confined to a wheelchair is denied adequate medical attention.

In such instances the local county Protective Service unit would provide protective services. On the other hand, if the client were to be deemed mentally ill or retarded and abused by a caretaker, guardianship proceedings would probably be undertaken by the State agency. Thus the condition of the client as well as the situation or circumstances are factors determining the use of social or legal interventions.

Wisconsin points out in its guidelines for its Protective Service System that many adults covered by its Protective Service Act are semi-competent rather than simply incompetent, that is to say they can peform some but not all of the tasks necessary to care for themselves and their property. To deal with this situation, the State has amended the States guardianship statute to permit appointment by the Court of a limited guardian of person (s. 880.33(3) or of the property (s. 880.37). Under a finding of limited incompetency, the Court must make a specific finding as to which legal rights the person is competent to exercise. Those not specified are transferred to the guardian. In reaching the decision as to which rights may be retained, the Court may

call upon the local agency involved in the case to provide additional evaluations and recommendations.

The State of Wisconsin asks a question: "What are the obligations of local agencies with regard to petitioning for guardianship?" Recognizing that anyone who appeared to be incompetent should be brought into Court, the State indicates some principles which can be guides to those who must make this decision to bring someone to court.

Pointing out that guardianship is a costly procedure and it is also a drastic measure, since it involves an action such as taking away someone's own right to make critical decisions affecting his own life and property and empowering someone else to make those decisions, staff is cautioned to be very careful in petitioning for guardianship of a recipient.

Guidelines local Wisconsin agencies might take into consideration include:

(1) There should be a presenting problem—that is, the probability of a person facing neglect, abuse, or exploitation unless provided with a guardian.

(2) Agencies must be especially concerned to petition for guardianship when a person's natural protectors—parents, adult children, contemporaries, other relatives and friends—are no longer available, willing, able, or trustworthy.

(3) It is not a good idea to inject the court into a familial relationship or to transform a familial relationship into a legal relationship, except for sufficient cause.

(4) Just because a person is determined by the Social Security Administration to need a representative payee for social security and SSI purposes does not imply that he needs a full guardian.

(5) An agency should not go into court to secure a guardian for someone in order to protect the agency itself. The agency's only consideration should be the need for protection by the individual for whom the guardianship is sought.[32c*]

Public Guardianship

Public Guardianship is a legal procedure carried out by an office of State Government specifically established under an appropriate State statute for the purpose of protecting the person or the estate (or both) of incompetent persons. Today 34 States carry out, explicitly or implicitly, a guardianship function.

A recent study on Public Guardianship and the Elderly conducted by the Institute for Social Research of Florida State University for the Administration on Aging in a number of States, reported that, without adult protective services programs, public guardianship increased, and also that the problem of ensuring due process and guarding the individual's other rights were of continuing concern in public guardianship cases.[33]

The study also revealed that public guardianship is provided to a majority of low income individuals, with females predominating. Caseloads in Public Guardianship Offices run to 100 or more cases per worker. In a number of States, fees for public guardianship are permitted. In Pima County, Arizona, 35% of the costs of the county's program of public guardianship was derived from fees for the service. The use of volunteers to carry out public guardianship activities is being considered by some States. Other States recognize the need to train professionals to staff public guardianship programs. It was pointed out in the study that restoration to competency of individuals adjudged incompetent is so rare as to be functionally non-existent (pp 135, 157, 191 ibid).[33]

Protective Placement and Commitment.

Placement or commitment are protective actions for persons who have demonstrated such a degree of incapacity that supportive services alone are not adequate. They are not always useful in crisis situations where quick action to stabilize the situation is called for, although they are used. They are best thought of when long range planning is possible and

*See Appendix T for example from the State of Utah--A Cumulative Impairment Score—Rating the client's ability to function in a social setting.

usually require more time to implement than is afforded in emergency or crisis situations. They require Court intervention.

It must be emphasized that the procedure for determining legal incompetency is not useful for those individuals whose mental functioning is impaired only intermittently. Therefore a number of States usually try, as indicated above, to have the Court use the least restrictive legal alternative consistent with the need to protect the client's best interests.

As mentioned earlier, most States provide for the initial evaluation of an individual by a licensed medical or psychiatric practitioner to determine his competency, health, mental health and need for protection. This examination may take place in a hospital, community mental health center or a physician's office. Usually, the person may have to be transported to the hospital by a relative or, if considered dangerous to himself or others he is transported to the facility by a law enforcement authority (municipal police, sheriff, marshal). During this period the individual is immediately advised of his rights, and evaluated. If the person is deemed competent, he is released to return to the community. If the person is adjudged incompetent for any of the reasons outlined above a petition is filed by the agency. A hearing is held before a Probate Judge. The person may be confined until the hearing, which is usually held within 72 hours of the evaluation. Counsel is usually available to such an adult. All of the legal procedures available to the defense will be available to him. If indigent, the counsel's fee is paid by the State Court. The Probate Judge will hear evidence as to the individual's competency or incompetency.

After hearing all the evidence, the Court may commit the individual for 30 days or longer. Outpatient care may be ordered beyond an initial 30 day hospital commitment. Again, the principle of the least restrictive kind of care is followed in modern commitment procedures which many States have adopted. The prosecuting attorney usually represents the petitioner (i.e.,, the State hospital, the Department of Social Services, etc..) at any hearing to commit a recipient of public assistance or other individual brought before the Court for this purpose. The defendent in the case may be represented by his own attorney or one appointed by the Court. Provision of immunity from civil or criminal liability is available to the person who transports an individual to the hospital for evaluation as an incompetent person. This careful, procedural approach reflects what the lawyers call "due process" and is an inherent right under the Bill of Rights.

Many States are aware of the need to use care in the treatment of individuals committed to State mental institutions as incompetent by reason of mental illness or other reasons. Treatment for such persons should be no more harsh, hazardous or intrusive than necessary to achieve a successful treatment objective for the person. In recent years the need to protect patients' rights in institutional settings has received growing attention from the public and advocacy groups as well as from the States.

Some States, like Arkansas, outline patients' rights in its mental hospital settings such as: to wear own clothes; keep personal possessions; spend a reasonable sum of own money; see visitors each day; have reasonable access to a telephone; receive unopened mail; refuse convulsive treatment (electro-shock) or psycho-surgery; be informed of hospital rules; be seen by the assigned physician without undue delay; and have the physician in charge of the case identified by name. Confidential treatment of all of his records; freedom to exercise rights to refuse to participate in medical experiments; right to file a complaint and to be free from harm; right to the exercise of religious freedom in practice and the right to prompt medical care and treatment is assured.

Outlining patients' rights, inside and outside institutions, is a practice which all States should follow.

Most States expect to receive payment for care of an individual committed to a mental hospital, usually from himself or his family.

Commitment for Emergency Treatment of Alcoholics

Some States provide for emergency commitment of alcoholics particularly if they have threatened, attempted, inflicted or are likely to inflict harm on themselves or another unless committed. In such instances an application for commitment to an institution for treatment may be made by a certifying physician, a spouse, guardian, relative or any other responsible person. If the administrator of such an institution, acting under State law, approves the application then the person shall be brought to the facility by a peace officer, spouse, relative or other responsible person. Until discharge, the person shall be detained in the institution. Normally five days are permitted for care and treatment. If the client is a recipient of service under Title XX, for example, the social worker in charge can make the application provided that facts to support the grounds for commitment exist.

Involuntary Commitment for Treatment for Mental Illness

States usually provide the caseworker with information on the steps to be taken regarding involuntary commitment of service recipients for treatment for mental illness. Nebraska, for example, provides that when the caseworker determines that an adult may need treatment because he/she is confused and disoriented to the extent that his/her well being is threatened and are dangerous, and there is substantial risk they are likely to cause injury or harm to himself/herself or others and has refused to seek treatment, the caseworker may request the county attorney petition the court for commitment.

If there is immediate danger of harm the caseworker shall request that the adult be taken into immediate custody, provide all available information as to the reason the adult requires protection to the law enforcement agency, consult with a mental health professional or a qualified physician/psychiatrist about the client's need for mental health treatment and/or involuntary commitment, and contact the county attorney to request that a petition for immediate commitment to an appropriate institutional placement be filed.[33a]

Other remedies may be available to the protective service worker. New York State in the Mental Hygiene Law (Article 9), authorizes the Director of Community Mental Health Services to have a person transported to an appropriate facility if he is acting in a manner which is perceived to be dangerous to self or others. In some jurisdictions the State law enforcement officials will not act in certain situations without the approval of the Director of the State Community Mental Health Service.[33b]

Because of current public policy in many States with emphasis on deinstitutionalization and on provision of services to recipients outside of long term care institutions, many States provide in their mental health laws for involuntary state mental hospital commitment of individuals deemed incompetent or incapable of self management for a limited time period. This period, usually of 30 days' duration, is deemed sufficient for an evaluation of the condition, short term treatment and, (unless otherwise determined), discharge back to the community. For some patients, this treatment is sufficient. For others it is not. One of the principal issues today is the question of the value of this policy, since it has created a "revolving door" syndrome for many who, when so discharged, return to the hospital within from 3 to 7 months for the same reasons that brought them there in the first place.

Older adults, particularly, are easy victims of this policy. Those who are discharged from a State hospital to an independent living arrangement after 20 years in a closed institution are completely bewildered and usually frightened. Neighbors may not be familiar to them. They are unaware of progress in the management of the home in the form of modern kitchen aids; they find supermarket shopping and mingling in large crowds unnerving. Carrying out these activities of daily living may be so unnerving that they become virtually immobilized. They are easy victims of crime. Often, they are unaware of their civil rights. Usually they make little effort to exercise their rights even if they know them. They may also have no

one ready, willing and able to help them responsibly—they need protective service! Shortly, they return to the original hospital or to a substitute nursing home placement.

Much needs to be done to make commitment to any long term care institution appropriate, safe, secure and desirable for older as well as younger adults who may need this kind of group living arrangement. Adult foster care placements may need to be expanded as a practical substitute for commitment or other legal protective placement, particularly for older persons with chronic brain syndrome.*

States should therefore exercise caution in such proceedings to carefully evaluate each individual's need and the Agency's basis in policy for commitment to an institutional setting, and ensure that a client's placement is in a group setting that best fits his specific needs for care. Careful evaluation may be cost beneficial in the long run. In the Agency's discharge process consideration of a range of suitable settings is indicated, if the intent is to find the most appropriate setting to match the individual's style of living and preferences.

Estimating Costs of Services

The total costs involved in providing whatever protective service system States offer have never been adequately gathered or interpreted.

"The best interests of the client" and "placement in the least restrictive environment" continues to be the current wisdom, particularly of the Courts, in providing Protective Service to Adults. Since community placements appear to meet these criteria, States, whenever possible, attempt to use them in carrying out their protective mandate.

There have been numerous studies but no good definitive answer to the question/controversy over the most cost effective setting—independent community living versus institutional long term care for multiply-impaired clients. Several methods used for estimating costs are also fragmentary or incomplete.

States continue to pay the total costs connected with protective services, particularly for the indigent recipient. In some instances documented evidence is available showing that States are paying good money for poor service and care, whether it is in poorly run institutional settings or in urban slum hotels or boarding homes. The lack of alternatives in the form of decent living arrangements in public or private housing has forced States to pay for care for clients in costly medically related nursing homes. The costs of care in such settings, many of them of marginal quality, is very, very high. This is the basis of complaints in the Congress and elsewhere about the need for care in a decent institutional setting providing social care (that is, a non-medical setting administered by a professional non-medical staff and providing benign oversight to the chronic but ambulatory person).*

The expansion of a long term care ombudsman program under the 1978 Amendments to the Older American's Act is one step toward improving conditions currently, in nursing homes and similar institutional settings.

States either provide protective services (in discrete or cluster packages) directly to their clientele or purchase them from other agencies. There are even variations on this main theme. Some States provide casework service as the linchpin of their protective service and purchase other ancillary services such as homemaker or chore services elsewhere. Other States purchase "protective service" packages from other service providers. National statistics on Adult Protective Services for the quarter ending March, 1978 indicated that 81% of the services States provided was by State/local staff; 15% was purchased from public agencies other than the Title XX agency, and 4% was purchased from local private social service agencies.** It is evident that from a nationwide point of view most of the costs of

*Refer to Chapter II — Client Characteristics, Section on senility.

*For a fuller discussion of this topic (costs of institutional care) see Rept. #93, Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper #1, prepared for the Subcommittee on Long Term Care of the Senate Special Committee on Aging. (X to XVI), December 1974.

**See Table 7, SSRR Interim Rept. 3rd Quarter, FY 1978.

Adult Protective Service are underwritten by the States themselves.

The national volume of the service is reflected in figures from the same report.

Approximately 650,000 primary recipients are served annually at a cost of 108 million dollars in the Title XX public service program. A recent study of 31 States showed 2,634 State staff only and 682 provider staff trained in FY 1978 to carry out Protective Service; 3316 staff overall. States have a long way to go in providing trained staff for carrying out adult protective services in view of the increasingly large numbers of individuals who are projected to need services by the turn of the century. They have an equally long way to go in estimating costs of the Service and its effects and benefits.

In their Comprehensive Annual Service Plans (CASP) for FY 1979, no Title XX State charges a fee for providing Adult Protective Service as a defined universal service. It is provided without regard to income. Fees are charged, however, for some of the components of the service cluster. (See above). Such components as homemaker service, chore service, legal services are examples. Some States do use the fees collected to increase the State share to earn the Federal matching share, thus increasing the numbers of people that can be served in this program.

In principle, if a ward's estate is available, the State when it acts as guardian will expect that the costs of guardianship will be paid from the estate of the ward. In some States, rather than beggar the ward, the State Service Agency takes a lien on the estate and collects after the ward's death, paying the guardian meanwhile. Also, if the ward recovers, it is easier to bill the estate leaving the remainder for the ward to use as he returns to alternate community living. This also becomes an incentive to deinstitutionalization.

It is up to Administrators and Managers to acquaint staff and service providers with these possibilities for using cost effective alternatives to institutionalization.

The emphasis on care and services in States affects the dollar difference between institutional placement and independent community living. Although it is hard to say which is more dollar-sparing, most states appear to believe good community care settings are more beneficial. One State (Maryland) provides for community home care for its aged. In one month (July 1979) the State provided this service to its aged clientele (2,643 persons). Other protective service activities consisted of foster care for the aged (101 persons); guardianship protective services (455 persons); institutional services (192 persons) non-guardianship protective services (none). The type and character of community home care is not described so it is not possible to judge the quality of service or care provided.[34]

Since in a number of States the costs of care for indigent individuals committed to State Mental Hospitals is borne by the State, the figures quoted above for Adult Protective Services may cover only those costs associated with social interventions in some States. The costs of legal intervention for institutional care would thus be additional. Unfortunately State data are not available to explain these cost differentials.

It is felt that the total costs of Protective Service for Adults should be examined by State planners in terms of:

(1) The costs associated with the initial social intervention in the crisis or emergency plan. (Usually within 10 days if State standards are to be accepted—see Chapter III).

(2) The costs for the middle period. In social intervention this is the period in which medical, psychiatric and social diagnosis and assessment occurs as a basis for a decision as to continued social intervention or referral to legal intervention. (Usually overlaps the crisis period in time but can run up to 30 days from the date of the initial examination by a physician or other team member.)

(3) Costs involved in the transition period. In legal intervention this is the period covering Court action to commit the incapacitated person to an institution or for establishing incompetency, selecting a guardian, and the termination of the Social Protective Service case if

resort to legal intervention is decided upon. In social intervention, this covers the remaining action of the staff in carrying out the individual service plan until termination of the case by the State/local agency. (Usually a short time for Court determination but may last up to 6 months and beyond in cases of social intervention and Protective Service follow up.)

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Chapter V

Issues

Introduction

This chapter deals with some issues arising out of the provision of protective services. The issues covered are: the place of protective services in the States' service program; the use of agency staff as client guardians; the impact of this service on clients' rights; what difference this service makes; and service integration.

States administering protective services are familiar with these issues. Local administrators struggling to develop a Protective Service program may find a discussion of these issues helpful in sorting out their planning and priorities as well as their own biases and convictions in this service area.

The Place of Protective Service For Adults in the Service Pantheon

Historically, States in the 50's and 60's were concerned with a narrow definition of Adult Protective Service which was focused on the seriously mentally and physically impaired older person. With the advent of Title XX States in the 70's expanded the definition to encompass all adults—covering anyone over 18 years of age. Adult Protective Service in States was modified to include adults who were found in circumstances or in situations indicating neglect, abuse, or exploitation. More recently, the problem of the mentally retarded and other adults suffering developmental disabilities, the chronically mentally ill, the alcoholic, the substance abuser, even "street people" and the victims of domestic family violence, became candidates for assistance as adults needing protective services.

As potentially vulnerable groups in the population increase, so does the expected number of those to be served.

This raises several questions of policy. First, do such categories of client population need the kinds of protection discussed in this monograph? Will limitations on funds available for this unique service require a "priority" or "triage" approach, limiting the services to those most in need of the social and legal interventions available in States? If so, what are the criteria for such selection? Are direct service staff in States that provide this service sufficiently well trained to deal with protective service referrals to individuals who range from "street people" to aged with depression, to developmentally disabled clients, to the chronically mentally ill, to women who have been beaten in a family disturbance?

If an analysis were made of individuals in the vulnerable groups noted above, the significant factor in determining the answers would be the problems presented, not the category of people served. If a problem-oriented approach is taken, services available may include preventive measures taken to reduce the risk of crisis and the possibility of costly care before it occurs, supportive measures to forestall recurrence of crises.

If someone reports that a neighbor isn't eating, referral to a congregate meals program where regular nutritious meals are available may be indicated. This is a supportive service which may preclude protective services later. Supportive services such as homemaker/chore services may be provided on a maintenance level over time for weak, frail and vulnerable people who can no longer carry out the activities of daily living without help from others. This may well avoid the use of commitment to an institution. "Preventive" and "supportive" services are provided to public welfare clients over the continuum of living.

"Protective" services are usually initiated at a point of crisis to prevent harm to endangered individuals. The social guardianship function common to public welfare agencies is social intervention in the client's best interests. Public social service staff intervene in their clients' lives in that they use social relationship techniques to assist the client in various ways to continue to

exert mastery over his own affairs and to solve crises in ways close to his own preferences. The expectation is that such "intervention" in the client's affairs to the extent necessary is consistent with maintaining or retaining his physical, mental or emotional functioning. This is because the social intention is aimed at strengthening the client's continuation of his own life style, not disrupting it.

Where the client's mental dysfunctioning is severe and seriously interferes with his ability to make sound decisions and choices in his own best interest and to manage his own affairs without assistance, and social intervention has reached the limit of professional social work service help or the limits set by State Agency policy, the protective social service worker will normally recommend the use of legal intervention to protect the client's person (guardianship) or his money or estate (conservatorship), or both.

In contrast to clients' voluntary acceptance of social interventive measures legal protective services are imposed on a client as the result of legal proceedings. The client allegedly is no longer able to function as a self reliant individual. At such a point a determination of "functional" incompetency on the part of the client must be made based on psychiatric examination. The matter is then referred to the Court by the Social Service Agency and an informal hearing is arranged at which the client's legal incompetency is determined and someone is appointed to serve as a guardian or a conservator.* Permanent placement in a chronic care institution often follows.

Resort to voluntary legal procedings in the case of severely mentally impaired aged has been discussed in a previous chapter.

A number of questions have been raised regarding the relationship between the legal and social work professions and their roles in carrying out protective services for adults. Some claim that Adult Protective Service is a social service with medical and legal interventions called upon when and if indicated. Others claim that Adult Protective Service should only include legal intervention.

Practical experience in dealing with adults, particularly the elderly, indicates that mental and emotional dysfunctioning, which is a principal factor in the determination of "incapacity" to handle money or protect his own person, may be transitory or may not mean he cannot exercise judgment or preferences in other areas or manage with help. Only when the dysfunctioning is sweeping and permanent is a determination of incompetency necessary. Indeed, inexpert or premature judgement of the client's competence and functioning capacity may sentence a temporarily confused and stressed old person to inappropriate permanent care settings. This risk is increased when only legal proceedings are resorted to.

As a practical matter as well as a moral obligation to protect the client's way of life social as well as legal intervention is called for. Furthermore, institutional commitment and guardianship, as legal proceedures, are an expensive way to protect people. The strength of current social intervention has been the worker's ability to quickly respond to a crisis situation, make a social diagnosis and plan and carry it out as sensitively and as expeditiously as possible in the client's best interest, and with proper respect for the client's rights. Study has shown such protective measures actually can preserve the client's mental functioning.** When it is evident that the client cannot manifestly continue to be self reliant then the use of legal proceedures is called for and suitable action is taken by the Social Service Agency to this end.

For those wishing to pursue this topic further the working paper on *Protective Services for the Elderly* published in July, 1977 by the U.S. Senate Special Committee on Aging should be reviewed in its entirety.

The Impact of Protective Services For Adults on Individual Civil Rights

It is difficult to offer a protective relationship and material services without encroaching on the independence and

*For further consideration of the advantages and disadvantages of legal protective service as applied in practice see Chapter V citation #10

**Report of the National Protective Service Project. DHEW SRS Publication No. 79-28959. Table 29.

autonomy of a needy person. In the case of impaired persons, particularly the aged, who are obviously dependent on help, the lines between providing services which the client desires, those to which he accedes, and those imposed upon him may blur. How can his human rights to self-determination be preserved while pressing him to agree to assistance he may find as intrusive as helpful? Several States try to deal with this problem differently in their policies on protective service, some by mandating forms of client consent (See New Mexico, below) See also reference to the State of Nebraska. These States are sensitive to the danger of overriding the client's wishes by authoritarian Protective Service workers.

The State of New Mexico, in its manual, pointedly states that a social worker will not violate the civil, constitutional or legal rights of clients.[8]

The State of Nebraska requires a signed contract between worker and client as a guarantee of client's rights. (See Appendix J) this causes the issue of cases where mental impairment in function may affect client understanding or decision making. This weakens reliance on such an instrument as a true reflection of the client's informed consent.

The State of West Virginia in its section on clients' right to self determination firmly maintains the client's right to choose to remain in his situation, as the policy of the agency. The client has the right to live as he chooses as long as he has not been determined incapable of decision-making by a Court of competent jurisdiction.[2] See Appendix H (Client's Rights to Self Determination).

The State of Iowa points out that the client has the right to refuse service or even to deny the need for protection.[4]

The State of New Hampshire, in its section on administrative and legal alternatives, points out that workers must, in all their interventions, balance two basic social work values in determining an appropriate course, i.e., the incapacitated adults' rights to self determination versus the Department of Welfare's responsibility to insure standards of health and safety for them as mandated under the State's statutes (proposed) to protect the welfare of certain adults. (RSA 161-D)[3]

Other States emphasize the public obligation to take action over the objections of clients in certain circumstances.

The State of Oklahoma, in its statute, "Protective Services for Elderly Persons," points out that when in the course of an investigation of abuse, neglect or exploitation the State Department of Public Welfare is denied entrance to the elderly person's home, the Department can petition the Court for an order allowing entry. When it is necessary to forcibly enter the premises the representative of the Department may make the entry accompanied by a peace officer.[5]

The State of Louisiana in its manual points out that some referrals are best made by a legal authority with follow-up service provided by the service worker. For example, when a referral indicates that an individual is unconscious and alone in his home, legal or law enforcement authorities are in a better position to initiate the necessary actions to obtain immediate aid for the individual since the service worker does not have legal authority to enter the individual client's home without his/her consent. Thus the service worker should encourage the referring person to report the situation to legal and law enforcement authorities.[6]

A different kind of situation around client consent is outlined in the following example: The State of Tennessee points out that, when an elderly person's caretaker refuses to allow the provision of such services, the Department may petition to the Chancery Court for a decree enjoining the caretaker from interfering with the provision of protective services to the elderly person.[7]

To recapitulate, the issue arising out of the impact of Adult Protective Service as provided by the State is one of abridgement of civil rights of the individual which are guaranteed under the Constitution. Serious mental impairment requires that the State intervenes to provide protection through the

use of social and legal agencies.* This procedure is at once protective of the person and invasive of his civil rights.

But who is there to guarantee that the client's rights are respected under due process, unless they have access to legal counsel to act for them? States' social service policies are usually silent on this matter.

It requires only an individual's consent, for example, for voluntary guardianship or commitment. If an individual after being committed for several years wishes to be discharged, his consent alone will not secure release unless he has voluntarily committed himself. If an individual is involuntarily committed to a mental institution, release is dependent upon the judgement of others, usually administrators of mental hospitals, to secure release. Even release from a mental institution will not restore civil rights such as entitlement to vote, or to contracts abrogated at the time of commitment and not restored by the Court upon release.**

A concern for the rights of aged clients in nursing homes has grown in the States administering public service programs. The development of an ombudsman program to act on behalf of the aged, particularly those who are institutionalized in long term care facilities, has recently been established under the 1978 Amendments to the Older Americans Act.

We have noted above how carefully States address the issues of client rights and service staff limitations respecting the rights of a client to refuse service.

Clients believed to need protective service should have full legal representation as soon as it is determined—no matter by whom—that they are no longer capable of money management and self management. This representation should be available throughout the course of the "protective service" process and it should be revived if and when needed, upon discharge from a mental or other institution, so that any civil rights abrogated in this process can be fully restored.

The Case Manager/Caseworker Staff as a Surrogate for the Client

States appear to differ in their utilization of direct service staff of the agency as representative payees, guardians or conservators of the funds or of the person of clients needing protection (i.e. serving as a surrogate or substitute for the client).

The issue is this: Should direct service staff of the State agency administering the Title XX public social service program under the Social Security Act ever be used in such a capacity?

In the course of this document, instances in which agency staff have served in a surrogate capacity have been noted. The principal advantage of such a procedure is the ease of administration since the agency does not have to find a person to act in a fiduciary role or in a surrogate capacity but has a candidate—the caseworker—handy to assume the role. Also, the question of confidentiality of records is assured inasmuch as the caseworker normally is the author of the records in question.

One State with this point of view has written as follows: "The position articulated in this section is that workers should not be placed in the conflicting situation of serving the client and managing his/her money. Although this position appears to have merit from a philosophical point of view, it poses real problems in terms of practical application. The provision of financial management services is very time consuming and difficult. Other community resources which are capable of providing these services are often reluctant to assume this responsibility on behalf of protective service clients. Because financial management services are often a critical component of protective services local district offices have no recourse but to provide these services directly when other resources are unavailable or unwilling to act in this capacity. If financial

*For a discussion of the limits of "Parens Partriae" doctrine see: Protective Services for the Elderly: the Limits of "Parens Partriae" by Peter M. Horstman, Missouri Law Review, Spring, 1975, Vol. 40. No. 2. p. 215. An interesting article on the tests of competency to consent to treatment discusses the concept as social and legal not merely psychiatric or medical. See citation p. 218. (#10)

**See U.S. Senate Special Committee on Aging. A Working Paper on Protective Services for the Elderly, July 1977, page 47 for additional examples of clients rights which are abrogated under these circumstances.

See also earlier references in this chapter on individual right and abridgement theory. (Horstman, Szasz and Bell)

management services are not provided in a timely manner, the living situation of the protective services client usually continues to deteriorate and institutional placements are often necessary. . . . although the provision of this service by district staff is not ideal nor perhaps preferred, it is often essential if the service is provided at all."

The disadvantage lies in the worker being forced to make decisions and help the client to make choices which may be in the agency's favor and possibly against the client's best interests if viewed by a third party. If a client is pressured by a worker surrogate to acquiesce in a matter of use of his/her funds in the agency's interest versus his own, then the client's rights to choice are being abrogated. As indicated earlier in this monograph, the intervention, social or legal, expressly limits the client in certain things, but not in all things. The worker/conservator or worker/guardian may tend to tilt the balance in favor of the agency rather than for the client.

It is at least awkward and at worst unethical for workers to be placed in this anomolous position. As a staff member, the worker is always viewed by others as the agency representative. If a staff member acts as a guardian or as a representative payee he may be confronted with situations where agency practices and policies conflict with traditional rights of individuals. In the author's view no worker should be placed in this contradictory position. It is a Catch 22 situation which serves no one well, least of all the client—the ostensible object of the State's protective service.

One means of alleviating the situation has been reported and is worthy of note. The Fairfax County (Va.) Area Agency on Aging is recruiting volunteers to serve as Court appointed guardians to mentally impaired elderly clients of the local Department of Social Services (DSS).[4a]

Protective Service to Adults—What Difference Does It Make?

While there are several ways of dealing with this question our preference is to deal with it in terms of effectiveness or outcomes where this can be demonstrated as well as the costs/benefits associated with the provision of this service. These are two factors which make a difference.

Successful service results may be judged when the critical circumstances and condition of the impaired individual are stabilized and improved and when his functional level betters.

At least one demonstration of Protective Service to older adults showed that in the areas of mental and physical functioning and the ability to secure and use available and safe housing as opposed to negative alternatives, an experimental group improved faster than the control group.[9]

The removal of an individual from a harmful situation—abuse by a caretaker or living in an unsafe house—and his/her restoration to a condition of safety, health and well being may represent a successful outcome as opposed to negative results of inaction—physical illness, mental illness or death from an unnatural cause(s).

A case in the study cited exemplifies the cost-benefits of removal from a dangerous situation. The costs involved included the service worker's time, plus such costs as payment for alternative safe housing; any use of consultants and any costs of legal interventions which might have been used in the process of protecting the client.

In such an example the *benefits* accrue not only to the individual client but to other responsible family members, the neighborhood and the community as well. These benefits from successful outcome of a service are evident to all. The individual client benefits by being removed from a harmful situation and restored to safety and a safe living environment. The family is satisfied. The neighborhood benefits. Neighbors who have a sense of responsibility and are outraged by situations in which vulnerable persons are neglected or abused or attacked are relieved when the crime is discovered, a person is rescued and a perpetrator is punished. The total community is a beneficiary. Harmony is restored and a blemish on its good name and reputation eliminated.

The data for comparison of the costs involved in providing these demonstration

services as against the more total care costs for the impaired elderly were not available, but since service workers were available and good institutional care was not, cost often amounted to a dollar value of a protected life versus that of a lost life or of death.

Protective services costs have been reported quarterly by States carrying out the Title XX public social services program. Compared to other services the quarterly costs of this service are not unreasonable. For example: the costs to States providing this program to individuals without regard to income as reported by States administering the Title XX Social Services program was $200; to SSI recipients $155; to Medicaid recipients $108; and to Income Eligibles $121.[10]

It should be noted that these figures probably do not include the *total* costs of an Adult Protective Service case since service programs are separately reported under the Federal Social Service Reporting Requirements (SSRR). To obtain total costs, the costs for all service components would need to be assembled, plus those service components not funded under Title XX.

Decisions on what service components to include in Protective Service are made in States on the "least costly alternatives" to maintain a certain level of "quality of life." This is a public policy issue worth further information and debate.

Service Integration

Is there any need to integrate the social, medical, legal and other components of Adult Protective Service? If so, whose responsibility is it?

Anyone who has been involved in the provision of human service to people who are found in various situations and circumstances is aware of the fragmentation of programs which, individually, were established to help people under different Federal, State and local laws. Although each of these laws has its own rationale and purpose, when joined together there tends to be overlap, lacks and gaps, even contradictions, and ultimately, confusion. Not all of the purposes of these programs are complementary. Consequently, when the question of protection of people is considered, there is a need to judge whether the social, medical and legal aspects involved in protective actions are sufficiently integrated so that by harmonious collaboration parts fully achieve the purpose of the whole.

For example: the police report to the Social Agency that the neighbors are complaining about Sally Smith. Mrs. Smith is an old woman who lives alone. She is a survivor. She owns her own home but it is in bad shape. It is ready to be condemned as a fire hazard by the Fire Marshall. She is mad enough to be considered eccentric but not rich enough to get away with bizarre behavior. A service worker is sent by the local agency to visit Mrs. Smith. Sparing the details, the conclusion is that Mrs. Smith needs to see a doctor. The physician believes that she may be unable to function alone and needs institutional care. A question arises. Who is legally responsible for Sally Smith? Ultimately, the Court may have to rule.

The professionals in this example represent the social, medical, legal, law enforcement and safety components of this protective service case. Not only do the different actors come from different backgrounds representing authority, but they are peers and completely independent of each other. No one is in charge.

States have dealt with such cases over the years. These cases are seldom identical and in fact, most are unique, calling for individual solutions. In dealing with such cases the issue of integrating the components is usually ignored. Some States have established a broad basis in Law—Adult Protective Service Acts. Other States have used the casework process and the public caseworker serves as case manager. Thus, the public agency attempts to integrate the components to achieve a service outcome consistent with the objectives of a case plan.

Some States have limited their protective services for adults to social services and nothing more and use the Department of Social Services to carry them out. Other States have used a consultation process and referral to the Court as the core of their "protective service" activity. Still other States have developed working agreements with other public or private service providers to

ensure access to services otherwise unavailable.

A harmonious working relationship between the social, medical and legal aspects in this service is obviously important. The service caseworker in Sally Smith's case needs the expertise of the internist, the psychiatrist, the visiting nurse and the psychologist, in addition to his own, to arrive at a comprehensive assessment of the physical, emotional and mental factors associated with Sally's ability to continue daily functioning in her present setting. The case plan, involving other disciplines, should include a series of options to deal with contingencies which might be expected in this client's case. Is it better to help Sally to repair her house and with a series of support services help her to remain in her own home? Does the Fire Marshall feel that the best solution is to demolish the house? If this occurs what kind of alternative living arrangement will be suitable for Sally? Will she accept this? Does the internist feel that Sally can make it on her own? Contrarily, does the psychiatrist feel that Sally's mental status is so tenuous and her hold on reality so weakened that she would constitute a danger to herself if she remained in an independent living status?

If the Police object to continuous calls from neighbors because of this client's disruptive behavior what needs to be done about it? If Sally's funds need to be protected who will do it? Is there any family member who will assume responsibility for Sally's welfare? If the Court is asked to intervene to protect Sally's person and she objects, who will be her advocate and see to it that her rights are protected? Finally, which agency will assign staff to seek and find available resources so that Sally can have choices as to her ultimate living arrangement? If she is placed in an institutional setting what responsibility for care and service does the institution assume? If Sally needs an operation, and has no responsible person to act on her behalf and give consent and she will not, what then? What responsibility does the Department of Social Services, assume in Sally's case?

Many States in their policy are silent on these issues. There is need to examine public social responsibilities of public service agencies to ensure that the Sally Smiths of this world do not fall between the cracks. States administering Adult Protective Service programs should consider, for example, their rules on case termination. It is irresponsible to take on clients into the service program and then abandon them when, for example, the client does not consent to a prescribed course of action suggested by the agency. Consent may be withheld not because the client is obdurate, but because the client's mental dysfunction—the cause of the protective action initiated in the first place—may be so serious that the client is actually unable to make a clear judgement or a decision which affects his own best interests. And he does not know this! Clients found in the situations and circumstances described with serious physical and mental dysfunctioning, are, normally, frightened and helpless. Persons with impaired capacities are certain to resist threatening changes which demand adaptability beyond their abilities. Here is where the most skilled counselling therapies must intervene to explain, reassure, and support to reduce the threat of recommended changes, and to allay anxiety and distress. This is the ultimate step in integrating a protective service plan. Administrators of State and local Departments of Social Service should seriously consider the need to adopt an integrative role and responsibility in Adult Protective Service case actions where they have not already done so. Administrators at the State/local level should be aware of the cracks and fissures in the fabric of the protective service shield. The social service system is the most universal of all the human service systems since it operates throughout communities and is also an expression of total community concern. To accomplish its protective service, it requires a total commitment from the State Executive Authority for funding and staffing.

It follows then, that the Agency responsible for the protective service system is in the most suitable and advantagous position to integrate—that is, draw together, not control—the other components of the Protective Service.

Obviously, respect for turf is important; so is the need for all professional disciplines to

work in cooperation with each other if Sally Smith is to be given her best chance for further survival. Additionally, mutual support can increase the effectiveness of each separate service program involved.

It is worth while for Administrators and Managers to consider this issue. The human service system embracing all of the components—Social Service, Health, Law, Housing, Police, the Court— will have to deal with increasing numbers of adults needing protection over the next decade or two. The pressures to close institutions and reduce beds, as well as longevity data, suggest that there will be more people in need of protection to deal with. And the work must be done, it seems, with fewer staff resources. An intelligent plan to integrate the components of protective service will do much to strengthen protective service for people needing such help.

Conclusion

This chapter on issues is intended to encourage States and localities carrying out Protective Services for Adults to develop a dialogue between the different actors in the public and private sector as well as a dialogue between various parts of the public sector, to examine these issues carefully and come up with prudent and practical solutions.

Goethe wrote, "There is nothing so terrible as ignorance in action." The intent of this monograph is to extend our present knowledge of Protective Service in action, and in so doing to raise further policy issues for solution by State and local administrators, planners, supervisors and practitioners. Only in this way can the service continue to be responsive to social change and human needs.

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Appendix A

Scope of Protective Services

State of Hawaii - DSSH
Public Welfare Division - Ch. II
Social Services
Protective Services for Adults
Service Manual Sect. 4111.04

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CHAPTER:	SECTION TITLE:
III - Social Services	Protective Services for Adults
SERVICES TO: Adults	PROCEDURES FOR MANUAL SECTION(S): 4111.04. page 1

Scope of Service:

1. Initiating Contact:

   a. Within twenty-four hours of receiving the referral, social worker initiates contact with the adult referred by telephone call to arrange a home visit or by home visit if introductory telephone call is not possible. If there is reason to believe the adult is in danger, police assistance may be requested to evaluate the situation through their "sick cared for", "injured cared for" and "miscellaneous assist" charges.

   b. Social worker identifies the purpose of the visit with the adult and, if appropriate, those with whom the adult lives or who are responsible for his care.

   a. Social worker focuses on the concern expressed by the referral, the Department's wish to assist the adult and/or, where appropriate, the caretaker if services are found to be needed.

   d. In many instances, a complete assessment will not be able to be completed in the initial visit. For this reason, access to the adult must be maintained. In the process of completing the assessment, the social worker has the opportunity to gain the adult's trust through a consistent display of concern, offers of assistance, and respect for the adult and his family's ability and right to be self-directing.

2. Casework/Counseling Services:

   a. Social worker discusses in detail the concerns expressed in the referral with the adult and, if appropriate, his family and/or caretaker(s).

   b. Social worker assists adult in identifying problem area(s) and alternatives, tried and untried, to handle them.

   c. If family/caretakers are involved in the protective situation, social worker assists them and the adult and to identify possible factors contributing to or causing the abuse or neglect and possible alternatives to having the situation continue.

   d. With the adult's knowledge and consent, social worker involves adult's children in providing assistance/supportive help to the adult.

   e. With the adult's knowledge and consent, social worker involves

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family/friends/collaterals in providing supportive help to the adult.

f. Document in narrative attempts made to involve family.

3. Where there is a need, social worker assists adult and/or responsible family or friends in obtaining community services or financial resources for the adult.

   a. Social worker explores financial and medical resources with the adult.

   b. Social worker assists adult in applying for income entitlements by taking adult to or arranging for him to be taken to applications' offices and completing the application or by bringing applications to the adult for completion.

   c. With the adult's consent, social worker refers the adult to medical or mental health treatment services. Social summaries requested by the treatment resource are provided only with the written consent of the adult.

4. Provision of Supportive Services:

   a. Social worker determines with the adult the areas of need.

   b. Social worker discusses with the adult services available through the Department and the community to meet the need.

   c. Social worker assists the adult in accepting the need for services.

   d. Social worker takes the adult to the service resource in the community on introductory visits.

   e. Social worker brings service provider to the adult's home on introductory visits.

   f. Where needed, social worker enlists the support of the adult's family, friends, collaterals to help adult accept services.

   g. Social worker maintains frequent contact with the adult to provide whatever services the adult can accept and to continue to offer other services needed.

   h. Adult agrees to utilize homemaker, chore, day care or health support services on a trial basis but is not willing to formally apply for the service.

   i. If not already done, social worker arranges and conducts introductory visit(s) between adult and service provider.

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(1) The adult may be an incapacitated person who is refusing services, and

(2) The adult is living in a situation dangerous to his physical well being and severe bodily harm or death may occur if corrective and/or preventive action is not taken, and

(3) The adult does not have responsible friends or relatives willing and able to act in his behalf or assume responsibility for the adult.

M.M. #78-21 12/29/78

Services shall not be provided the adult against his expressed wishes unless he has been adjudicated an "incapacitated person" by the Family Court and a legal guardian appointed. Individual Adjustment Services may then be provided the adult at the request of or with the consent of the legal guardian.

j. Provision of Homemaker Services:

1) Social worker confirms earlier telephone contact with Homemaker—Coordinator regarding the availability of a Homemaker for the adult and submits "Request for Homemaker Services for Adults", PW-130B.

2) Social worker and homemaker meet with adult service.

3) Social worker and adult define services needed with the homemaker. Compromises may need to be made in providing fewer services than are needed until the adult is ready to accept all services needed.

4) Social worker/adult/homemaker agree on the hours/days/ and estimated length of time services are to be provided.

5) Social worker continues involving the adult in the knowledge that services without regard to income can extend for a maximum of ninety (90) days during which the adult may choose to terminate or formally apply for services.

6) Social worker and adult complete Homemaker Service Agreement, PW-131, in triplicate each retaining a copy and one copy given to the homemaker.

k. Provision of Chore Services:

1) Social worker confirms earlier telephone contact with POS chore

provider or choreperson to be hired by the adult regarding the availability of the choreperson for the adult.

2) Social worker and choreperson meet with the adult needing service.

3) Social worker and adult define services needed with the choreperson. Fewer services than are actually required may need to be provided until the adult is ready to accept all services needed.

4) Social worker/adult/choreperson agree on hours/days and estimated length of time services to be provided.

5) Social worker continues involving the adult in the knowledge that services without regard to income can be extended up to a maximum of ninety (90) days during which the adult may terminate or choose to apply for services.

6) For Cash Payments:

   a) Social worker explains reimbursement payment to choreperson and the adult and the need for monthly receipts.

   b) Social worker completes PWS-4, PWS-5 for cash payments under category Y/R. Complete blocks 659 and 668 of PWS-5. Refer to Service Payment Instruction Manual.

      Effective 10/77, complete blocks 500 and 502 with program type "H" and subcategory "R" respectively. Complete block 682 or 695 with eligibility code "Y". Complete block 659 or 665 and 668, with payment amount.

      Refer to Service Payment Instruction Manual.

   c) Adult secures receipt of payment from choreperson and forwards to social worker.

   d) Social worker files receipt on inside cover of case record.

   e) Social worker maintains regular contact with the adult and choreperson and personally assists adult in securing a receipt when necessary. In considering the adult's situation, if securing a receipt is not feasible, social worker secures verbal verification of payment from the choreperson. Record verbal verification and file, similar to receipt.

7) For POS Payments:

   Social worker completes PWS-4 and DSSH 1604 (PWS-3B). Effective

10/77, identify program type "H" next to 9-digit case number; identify category "Y" on DSSH 1604 (PWS-3B).

8) Social worker/adult/choreperson complete a "Chore Service Agreement" when greater or lesser services are agreed upon. Forward fourth copy of the agreement to the POS provider when POS services used.

1. Provision of Adult Day Care Services:

1) Social worker confirms earlier contact with Adult Day Care facility regarding the availability of space for the adult.

2) If not completed earlier or if necessary again, social worker takes adult as well as family and/or friends on pre-placement visit to the facility.

3) Where necessary, social worker assists the adult in arranging for transportation to the facility. Where transportation through a POS provider is arranged, social worker completes DSSH 1604 (PWS-3B), "Notification of Disposition of Application", authorizing POS services.

4) For purchase order payments:

a) social worker completes PWS-4 and forwards P. O. to the day-care facility monthly under category Y. File copy of P. O. on inside back cover of case record. Identify program type "H' and category "Y" on P. O. effective 10/77.

5) For POS payments:

a) social worker completes PSW-4 and DSSH 1604 (PWS-3B), forwards DSSH 1604 (PWS-3B) to provider.

Effective 10/77, identify program type "H" and category "Y" on DSSH 1604 (PWS-3B).

6) For cash reimbursement:

1) Adult presents a bill to social worker for services rendered by the day care facility or a receipt for payment made to the facility for services rendered.

b) social worker completes PWS-4 and PWS-5 under eligibility category Y.

Effective Date: 10/77

Effective 10/77, complete blocks 500 and 502 of PWS-5 with program type "H" and subcategory "R" respectively. Complete block 682 or 696 with eligibility code "Y". Complete block 669 or 685 and 668 with payment amount. Refer to service payment instruction manual.

c) Adult secures receipt and forwards to social worker if not already completed.

d) Social worker files receipt on inside front cover of case record.

e) Social worker maintains regular contact with the adult and personally assists in securing a receipt if necessary. In considering the adult's situation, if securing a receipt is not feasible, social worker secures verbal verification of payment from the day care facility.

m. Provision of Health Support Services:

1) Health support services may be provided on the initial contact with the adult or at a later time.

a) social worker contacts the Department of Health Public Health Nursing Office to request that the PHN assist in assessing the health care needs of the adult.

b) the social worker and PHN contact the adult.

c) social worker and PHN discuss their findings and agree on the continued need for PHN services or discharging the adult from service.

d) social worker completes DSSH 1504 (PWS-3B) and forwards to provider (applicable to branches where there is an existing contract for PHN services). Effective 10/77, identify program type "H" and category "Y".

e) If PHN services are to continue, social worker and PHN or health aide maintain regular contacts with each other and the adult. Provider and social worker consult regularly for case planning.

n. Provision of medical evaluations:

1) When no other resources are available and a medical evaluation

of the adult is necessary, the cost of such evaluation may be provided.

a) social worker and, when appropriate, PHN discuss their determination of the necessity of a medical evaluation with the adult.

b) social worker assists the adult in securing a medical evaluation.

c) if the adult has no physician and has no preference, if at all possible, secure the services of a Medicaid provider.

c) inform the physician that we will be assisting the client in applying for Medicaid benefits and that if, by the end of the ninety-day period, the client refuses to do so or is subsequently found to be ineligible by Medicaid standards, payment will be made as a social service cost. Issue purchase order payment following item (e) below.

e) If the adult has or chooses a physician who does not wish reimbursement through Medicaid, secure the charges for the medical evaluation and issue a purchase order using the following codes:

care services, social worker and adult secure opinion(s) of the adult's physician, and PHN by telephone contact, office visit, or on VR-PWS-2, PW-50A or PWS-109 as appropriate.

h. With the adult's tentative agreement to placement, social worker completes "Placement Request Card for Adults", PW-41A and submits to unit coordinator, or consults "Care Home Vacancy List" from the Department of Health.

i. Social worker reviews AFBH records suggested by the unit coordinator on PW-42A.

j. Social worker selects the AFBHs or care homes most closely meeting the needs and preferences of the adult.

k. Social worker contacts the AFBH or care home operators' and discusses the adult's needs and determines the operators' ability and willingness to provide care to the adult.

l. Social worker discusses the potential homes with the adult and arranges pre-placement visits between the adult and the homes including,

wherever possible, relatives and friends.

m. Social worker takes adult/friends/relatives on pre-placement visits and assists the adult and operator(s) in discussing the adult's needs and in defining the roles and expectations of each to the other in the home(s).

n. Adult selects home. The adult may need more than one pre-placement visit in any one home prior to making a selection. Even if only one home is being considered, this should be encouraged.

o. Social worker reiterates adult's special needs with the operator and how these may be handled.

p. Social worker, adult, operator determine placement date.

q. Social worker certifies the level of care to Social Security Administration on SSA 8221 and explains payment process and coverage to the adult and operator.

r. If not already completed, social worker assists adult in securing or arranging for medical coverage and explains medical care/payment procedure to adult and operator.

s. Social worker completes PW-113 and gives one copy to the operator.

t. Social worker places adult into foster care with family/friends if involved.

u. If placement is into a care home, social worker and operator complete DSSH 1502, "Agreement Between the Department and Domiciliary Care Facility", each retaining a copy.

6. When foster care services and a range of supportive services are insufficient to maintain the adult in the community, the adult's feelings about moving to an institutional setting must be explored.

a. Where possible, social worker assists adult in evaluating alternatives to institutional placement.

b. Social worker assists adult in securing opinion(s) of the adult's PHN, physician, Mental Health Clinic staff, their involvement and recommendations if not already aware of and involved in the adult's situation.

Social worker assists adult in accepting that available supportive services are insufficient to maintain him safely in the community.

d. Social worker provides supportive help to medical personnel who

are arranging institutional placement:

1) with the adult's written permission, providing social summaries needed to facilitate admission

2) continuing to work with the adult, family, friends around the need for admission

3) continuing to involve and prepare the adult and significant others for the adult's admission

4) working with the adult and friends/relatives around their feelings about the possible separation, adaptations that may be needed in the home

5) assisting the adult, friends, relatives in visiting the institution where possible and needed

6) anticipating with the adult, friends, relatives the changes/ adaptations, possible problem areas the adult may encounter in the facility and what they or he might do to resolve or ease the situation

7) preparing the adult, friends, relatives to work with the facility's staff and for the transition to the facility's social service staff.

e. Social worker assists in arranging or providing transportation to admit the adult when necessary and feasible.

7. Initiating guardianship proceedings: In very few instances, guardianship proceedings will need to be initiated in order to institute services to an adult who requires but totally opposes or is in such a condition that he cannot consent to services. Because guardianship involves taking from the adult the right and ability to make decisions for and about himself and because the process itself carries a negative meaning for the adult, this process is used only as the last alternative in providing safety for the adult and only after detailed consultation with the Deputy Attorney General. Guardianship petitions shall be limited to those areas in which the adult's decision-making powers are seen as insufficient to sustain him safely if left alone.

Court action may be initiated at any point in our contacts with the adult after it has been determined that the adult may not be able to make responsible decisions, that he has no one willing and able to assume responsibility for him and that his situation is such that bodily harm or death may occur if action is not taken. The guide used to determine need

for protective services may also be applied to determine need for court action if the adult is threatened with harm or death.

a. Social worker determines that petitioning for guardianship may be necessary.

b. Social worker and supervisor discuss case situation, possibility of other options, timing, need for additional information.

c. With supervisory approval, social worker contacts Deputy Attorney General to determine whether there are sufficient grounds to proceed with a petition for guardianship.

1) social worker presents to the Deputy:

a) facts/observations of the adult, his situation, his resources

b) any previous referrals

c) efforts made by the Department to assist the adult and results

d) efforts made by others to assist the adult and results

2) Deputy Attorney General determines whether there are sufficient grounds to proceed with the guardianship petition

d. Social worker informs the adult of the plan to petition and assists adult/family/friends in securing legal counsel for the adult.

e. Deputy Attorney General assists social worker in preparing the petition for guardianship.

f. Social worker prepares a cover letter and social summary to be submitted with the petition through the Attorney General's office. Social summary should include:

1) Name, address, birthdate of the alleged incapacitated adult

2) Names, addresses, phone numbers of friends/relatives of the adult and their interest in acting in the adult's behalf. If no friends or relatives have been located, attempts made should be documented.

3) Name, address, telephone of the guardian of the property, if any.

4) Names of other agencies/Departments interested in the welfare of the adult and their interest in being appointed guardian.

Effective Date: 10/77

5) Description of the situation that makes the petition necessary including a summary of previous referrals, the Department's response and the case disposition, efforts made to involve friends/relatives to act in behalf of the adult or assume responsibility for him.

6) The specific areas to which guardianship is recommended to be limited, e.g. authority to consent to medical care only, authority to determine the adult's living arrangement.

7) The recommendation that a guardian of the person be appointed specifying the position of the Director of the Department.

8) The treatment plan the Department is recommending for the adult including the services to be provided to the adult in his home, or if applicable, the name of the facility where the adult will receive care and the nature of the care to be provided. If care in a facility is expected to be of short duration, the plan following discharge should be specified.

9) The efforts made to assist the adult in securing legal counsel and, if unsuccessful, the recommendation that a court appointed legal counsel and guardian ad litem be named.

10) The recommendation for a judicial review in six months.

g. In the event a crisis/emergency exists, the Department may petition the court for the appointment of a temporary guardian (the court may appoint itself or an interested person or agency).

1) Social worker discusses the need for immediate action with supervisor

2) With supervisor's approval, social worker confers with legal counsel for a determination of the adequacy of grounds for a petition for the appointment of a temporary guardian

3) If there are sufficient grounds to proceed, legal counsel assists social worker in preparing and filing the petition with the court

4) Social worker forwards the petition to the court through the Attorney General's office with a summary of the situation which makes the petition necessary and a recommendation of the immediate action needed

8) If the Department is appointed temporary guardian, the social worker will prepare and forward to court through legal counsel a detailed summary, treatment plan and recommendations

h. Social worker submits a supplementary report to the court through legal counsel immediately on learning of changes in the adult's situation.

i. If the Department is awarded guardianship, the social worker complies with any court orders. In the event a court order cannot be carried out, the social worker immediately informs legal counsel.

j. If the Department is awarded guardianship, social worker prepares and submits through the Attorney General's office, prior to the time of the six-month review, a summary of the facts following the granting of the petition and recommendations on the case.

Appendix B

Scope of Protective Services

State of New York
Bulletin # 194
Pages 7 - 11

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B. Title XX

Protective Services for Adults in most instances are subject to the requirement of Title XX of the Social Security Act. The following definition and list of service activities are in the Comprehensive Annual Social Service Plan (76-77). To this has been added the Department's interpretation of the general activities which might be involved but this is not intended to be an all inclusive list.

1. Definition: Services to individuals 18 years of age or older who are unable to protect their own interests, harmed or threatened with harm through action or inaction by another individual or through their own action or inaction due to lack of awareness, incompetence or poor health which results in physical or mental injury, neglect, or maltreatment, failure to receive adequate food, shelter, or clothing, deprivation of entitlements due them, or wasting of their resources.

   Such services are limited to:

   (a) "Identifying such adults who need assistance and have no one willing and able to help."

   Interpretation: (Includes but not limited to the following.)

   - Community education and outreach
   - Intake screening to identify persons in need of referral to Protective Services to Adults.

- Review of caseloads by Income Maintenance, Medical Assistance and Services for identification of adults at risk.
- Referral of those adults as mandated or recommended by other Department regulations or releases e.g. applicants for Emergency Assistance and those adults for whom protective payee or representative payee is designated.
- Determining the availability of responsible family members and securing such person's help and cooperation.

(b) "Providing prompt response and investigation upon request of adults or risk or other persons acting on their behalf."

Interpretation: (Includes but not limited to the following)

- Establishes responsibility to take action for voluntary and involuntary clients at risk.
- Prompt action mandated, agency should set reasonable time schedule.
- The response may involve securing emergency services.
- Crisis situations may involve police, legal, medical, and/or psychiatric services.

(c) "Diagnosing the individual's situation and service needs."

Interpretation: (Includes but not limited to the following.)

- Involvement of client to greatest extent possible.
- Development of a service plan.
- Establishes casework — case management role.
- Identification of specific service needs.
- Contacting relatives, friends, landlords, neighbors, as well as direct contact with client.
- Consultation with other resources as medical, psychiatric and legal.

(d) "Providing counseling to such adults, their families, other responsible persons or to surrogates such as representative payees, on handling the affairs of such adults."

Interpretation: (Includes but not limited to the following.)

- Case management role. Direct services counseling to enable client to accept needed services.

. Involvement of other concerned persons and resources, relatives, legal resources, health services, Social Security, others as indicated.

(e) "Arranging for appropriate alternative living arrangements in the community or in an institution."

Interpretation: (Includes but not limited to the following.)

. Case management — action based on case study and diagnosis.

. Involve client to greatest extent possible.

. Emergency placement in crisis situations.

. Securing services such as homemaker, housekeeper to alleviate the harmful conditions, and permit client to stay in own home. Securing needed repairs.

. Relocation to more appropriate housing and arranging for necessary services (meals, personal care, housekeeping, etc.)

. Counseling with client and staff of health and/or legal resources about the need for and type of institutional care available. Arranging for such care.

(f) "Assisting in the location of social services, medical care, and other resources in the community including arranging for day care in a protective setting."

Interpretation: (Includes but not limited to the following.)

. Case management — locating and securing needed services.

. Includes foster care, health related, home management, homemaker, housekeeper, housing improvement, prevention, social adjustment, social group services.

. Medical care (including psychiatric) for the purpose of determining the extent of client's physical and/or mental incapacity and the services needed.

. Other resources — included would be such services as friendly visiting, home delivered meals, help from relatives, friends, churches, senior citizen centers.

(g) "Arranging for guardianship, conservatorship, commitment or other protective placement as needed."

Interpretation: (Includes but not limited to the following.)

- Guardianship and commitment involves legal consultation and court procedures. Such action mandates study, evaluation and formulation of agency policies.
- Conservatorship must be considered prior to commitment. Role of agency in initiating conservatorship proceedings or serving as a conservator should be undertaken in consultation with legal representative.
- Protective placement includes foster homes, relative or friend's home, services in own home which would ensure protection and adequate care, as well as congregate care.
- Action related to above will often be preceded by arranging for psychiatric and/or medical consultation.
- Important to differentiate voluntary and involuntary client, and define agency role.
- Emergency action may be indicated.
- Agency has responsibility to stay with situation until condition is improved, corrected and danger to client eliminated.

(h) "Providing advocacy and assistance in arranging for legal services to assure receipt of rights and entitlements due to adults at risk."

Interpretation: (Includes but not limited to the following.)

- Assistance in obtaining SSI, Medical Assistance, pensions, community discounts available for elderly, food stamps. May mean filing applications, help in obtaining necessary documents.
- Guidance with fiscal matters — security measures re: checks, protection of property. Assistance with income and property tax problems.
- Evaluate need for protective and/or representative payee and take necessary steps to secure same.
- Interceding as with landlord to ensure provision of housing services, needed repairs.
- Assistance in obtaining proof of age.
- Assistance in obtaining a fair hearing.

(i) " Functioning as a conservator representative payee or protective payee where it is determined such services are needed and there is no one else available or capable of acting in this capacity."

Interpretation (includes but not limited to the following:

Initially search for responsible family member or friend to serve in such capacity.

Establish criteria on need for such services

Differentiation of elements of conservator, representative payee protective payee

Consultation with legal representative indicated for conservatorship

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Appendix C

Eligibility Criteria

State of Hawaii - DSSH
Public Welfare Division Ch III
Social Services
Protective Services for Adults
Service Manual Sect. 4111.02

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Eligibility:

Protective services are offered and providing to adults without regard to their income. However, a determination of the need for such a service needs to be made whether the adult lives alone, with others or in an out-of-home arrangement. The determination should be based on information gathered in at least three areas: the adult, the situation and the resources available to the adult. In pulling the information together and evaluating the significance of the information as it pertains to the adult in his situation, the strengths and abilities of the adult need to be weighed along with his problem.

The following describes some of the factors that should be considered in evaluating and determining the need for protective services:

1. The Adult

   a. Is/is not able to understand and be understood.

   b. Has/has not appearance or complaints of unusual thinness, pallor, paralysis, tremors, speech difficulty, excessive fatigue, weakness, falling, dizziness, persistent pain, other physical symptoms.

   c. Does/does not appear to be mentally alert, mentally retarded, mentally ill.

   d. Has/has not frequent or prolonged periods of depression, crying, apathy, feelings of persecution, excessive nervousness, irritability, explosive anger, other emotional symptoms.

   e. Does/does not appear interested in dress, cleanliness, daily living activities, self.

   f. Does/does not appear interested in or aware of the environment with which he must deal.

   g. Is/is not able to manage personal care, medical care, financial and living needs independently.

   h. Is/is not self-mutilating, threatening suicide, threatening physical harm to others.

2. Situation

   a. Is/is not being (or threatened with being) beaten, whipped, burned, having food intentionally withheld by those responsible for his care.

   b. Is/is not being (or threatened with being) chained, tied

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up or otherwise forcibly restrained by those responsible for his care.

c. Is/is not lacking in provision of adequate food, shelter, clothing, access to medical care, attention to personal and incidental needs by those responsible for his care.

d. Resources are/are not being managed to meet personal care, food, shelter, clothing needs by self or caretaker.

e. Medical care needs are/are not being met by self or caretaker, i.e. arranging for medical care, getting to medical service resource(s), following through with medical recommendations.

f. Personal care needs, daily living activities are/are not being met by self or caretaker, e.g. food preparation, laundry, shopping, cleaning.

g. Living situation is/is not hazardous to health and safety of the adult, e.g. has/has not adequate light, potable water, safe plumbing and building structure; is/is not fire hazard due to debris, defective wiring.

3. Resources

a. Has positive/negative relationship with friends/relatives. Friends/relatives are/are not maintaining regular contact with the adult. Friends/relatives are/are not assisting the adult. Knowing the adult's situation, friends/relatives are/are not willing to assist further. Others have/have not assisted the adult in the past and are/are not willing to assist again.

b. Has/has not a guardian of the person or estate. Has/has not delegated power of attorney to another.

c. Has/has not requested or applied for services or help from others before. Has positive/negative relationship with previous helping person/agency. Is/is not willing for person or agency to be contacted for services again. Type(s) of services earlier provided.

d. Is/is not currently active with another agency for services. Has positive/negative reaction to the agency's services. Is/is not willing for the other agency to be contacted.

e. Has/has not income or resources to meet living needs, personal essentials and incidentals, medical needs. Is/is not receiving a regular monthly income. Has/has not applied for income

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entitlements. Is/is not willing to apply for income entitlements. Family/friends do/do not help financially or in kind.

f. Is/is not receiving medical/psychiatric care. Has/has not a regular doctor, PHN, medical clinic. Is/is not willing to seek medical care services.

If the evaluation indicates a need exists, the adequacy of the resources available in the area(s) of need are assessed. The primary concern is whether the basic sources of help are available to the adult and are being used appropriately and to their maximum. The considerations that need to be made are:

1. Are the resources currently in use adequate for the situation or are additional resources needed?

2. Are Departemental services needed to help the adult utilize the resources more effectively or to secure other and more appropriate services?

Appendix D

General Principles

A Framework for Protective Services
for Adults

State of Mississippi
Service Manual pp 3 - 4

IV. The Framework of Protective Services

A. General Principles of Protective Services

In all services provided by the Department of Public Welfare, it is most important that the legal rights and personal dignity of the client be guarded very carefully. Such protection of rights and dignity takes on increasing importance when dealing with persons who are in need of protective services. When the client can no longer look after his own interests, and does not have family or friend who can and will do so for him, it becomes the responsibility of the Department of Public Welfare to try to protect the client against himself and against the actions of others that are not in the client's best interest.

1. Efforts of the adult services program are to be directed toward preventing the deterioration and crisis situations that require protective services.

2. The rights of self-determination must be assured to the greatest extent possible for each client. Every adult, regardless of age or condition, has a right and a responsibility to direct his own life to the extent that it is possible for him to do so. This means that each client should be given every opportunity to make plans for himself, and if possible, he should be offered alternatives for his consideration and choice.

Although the case work principle of self-determination requires that clients be free to make their own decisions, it is the responsibility of the agency to preserve the client's rights when the latter's capacity for self-determination is impaired. In providing protective services there may be situations in which the agency will consciously try to influence the client or those interested in him in favor of a plan which the agency believes to be best for the client. In arriving at a decision to do so, the client's total living arrangement must be considered. Not only is it important to consider the immediate conditions but also what strengths the clients has to deal with the situation, the attitudes of the client, the client's coping abilities and the sustaining influences the client can expect to receive from family or friends.

3. If the client is unable to act in his own behalf, help of responsible relatives or other appropriate persons must be sought, both because their help with planning and their moral support are usually needed by the client, but also because the Department of Public Welfare is to act for the client <u>only if he has no guardian or relative or other appropriate person able, willing and available to assume the kind of degree of protection required under the circumstances</u>.

County staffs are to make full use of the knowledge and skills of other professionals in determining the client's ability or lack of ability to make his own decisions and also in planning for the client. Consultation with other professionals can provide valuable help in determining how dangerous the client's situation may be and how urgently change may be needed because they see the client's problems from different perspectives. For example, a physician's examination might reveal a condition that calls for immediate hospitalization or, on the other hand, might determine that a condition which gives the appearance of serious illness can be treated adequately in the client's home.

4. A condition requiring intervention in the client's behalf may be temporary and/or reversible. Proper medical care, nutrition, rest, etc., may enable the client to return to independent living. This possibility must be kept in mind as his situation is evaluated.

5. Taking steps to forcibly intervene in client's life can have a drastic effect upon both the life of the client and the relationship of the agency with the community. The service worker's supervisor and the County Director must be kept fully informed at all stages of the planning.

6. If the client who is capable of making such a decision wishes to continue his current living arrangement, consideration must be given to that wish and whether the use of supportive services such as day care, homemaker, home delivered meals, etc., would make that arrangement preferrable to moving the client.

7. In providing data to the courts regarding individual situations and the need for protective services, the service worker must be sure to proceed on the basis of verified facts and/or professional judgment, rather than hearsay or impressions.

B. Rights of Adults

When an individual harmed or threatened with harm is unwilling to accept services, the worker must utilize casework skills in an effort to assist the individual to understand the benefits of social services in his situation. Relatives, other agencies or other interested persons should be enlisted in this effort when feasible. However, in the provisions of protective services, an important casework principle is that of self-determination, more specifically, the right of the individual to make his own decisions and choices as long as he is not in violations of laws, ordinances or regulations Therefore, if the individual refuses services or refuses access to this person the worker must respect his decision.

C. Rights and Responsibilities of Children, Relatives, Caregivers

Whenever possible, children, relatives, or interested persons of adults who are in need of protective services should be notified immediately in an effort to enlist their assistance in helping the abused, neglected, and/or exploitated adult. Notification of interested parties is a must when commitment proceedings are involved. In most cases, children, relatives, or interested persons, will consider it their right and responsibility to assist the adult rather than Department of Public Welfare.

D. Authority and Role of the Department

The Department of Public Welfare is the designated agency to provide adult protective services under Title XX.

The County office is responsible for conducting protective services investigations involving adults who are harmed or threatened with harm in order to establish their eligibility for social services under Title XX. The county office is also responsible for the provision of protective services to eligible individuals either by direct delivery or by referral to another resource in the community.

E. Rights and Responsibilities of the Courts/Law Enforcement Officer

Referral to a legal authority will be appropriate in some cases when individuals are harmed or threatened with harm. Referral to a legal authority is more appropriate when the condition is related in some manner to a violation of State or local laws, ordinances or regulations. It is preferable for members of the individual's family or other persons concerned about the individual's well-being to make such referrals; however, the worker may do so if there is no one else to act responsibly for the individual. The service worker and supervisor shall evaluate the facts of the situation to determine legal authorities for the resultant condition of harm to the individual. Workers should also be knowledgeable about legal resources, such as Legal Aid Societies, so that appropriate referrals may be made in situations when individuals are being deprived of their rights. Frequently, agencies such as the Social Security Administration will conduct investigations in instances where the individual's resources are being wasted by a third party.

In situations where commitment of a individual to an institution may be indicated, it is the responsibility of the individual, friends or other interested persons to take the initiative in referring the situation to the police. The service worker, as a representative of the Welfare Department, shall not be a party to initiate procedures for commitment.

Appendix E

The Assessment Process

State of New Hampshire
Service Manual
Item 672 pp 5 - 8

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Assessment of the Referral
5605.6

a. Whenever possible, the social worker and referred adult assess the adult's situation and together determine whether or not Protection Program services are necessary and which services will be provided.

These questions will assist the social worker and client to assess the referred situation:

1. Has neglect, abuse, exploitation or hazardous living situation occurred? Has this situation continued into the present?

2. What has the individual tried to do about the situation?

3. What does the individual want to do about the situation?

4. What can and will the individual do about the situation?

5. What does the individual want the Division to do about the situation?

6. What does the Division believe should be done?

b. The social worker bases his or her assessment of the referral on his or her observations, the discussions with the referred adult, and information from the collateral contacts. From this assessment the social worker determines whether or not:

POLICY (continued)
5605

Assessment of the Referral
5605.6

1. The referred adult is physically, emotionally or mentally incapacitated.

2. The neglect, abuse, exploitation or hazardous living situation exists and, if so, the conditions and actions which constituted the neglect, abuse, exploitation or hazardous living situation.

   (a) Characteristics of all neglect, abuse, exploitation, or hazardous living situations include:

      (1) The abused adult's physical mental or emotional deficiency that renders him or her incapable of managing himself or herself or his or her affairs.

      (2) The degree of danger to the neglected, abused or exploited adult or the adult residing in a hazardous living situation.

      (3) The perpetrators role in the neglect, abuse or exploitation of the adult.

   (b) Characteristics specific to adult abuse are:

      (1) The pattern and nonaccidental character of the injury.

      (2) The perpetrators role in the alleged abuse.

   (c) Characteristics specific to adult neglect are:

      (1) The neglected adult's pattern of conduct that reflects deprivation of services that are essential to minimum mental and/or physical health.

      (2) The absence of a reliable and adequate protection source.

      (3) The caretaker's awareness of the neglected adult's situation and consequences.

POLICY (Continued)
5605

Assessment of the Referral
5605.6

(4) The caretaker's inability, unwillingness or unaccountability for the arrangement, provision or acquisition of the services essential to the neglected adult's well being.

(d) Characteristics specific to adult exploitation are:

(1) The improper use of the incapacitated adult or his or her resources.

(2) The taking of or disposing of the incapacitated adult's resources without approval or under false pretences and for another's profit or advantage.

(e) Characteristics specific to the hazardous living situations of adults are:

(1) The adults willingness to correct the hazardous living situation.

(2) The availability of resources to correct the hazardous living condition and maintain an appropriate living situation.

3. The referred adult is lacking in ability to delegate responsibility to a caretaker and/or the adult is lacking reliable or adequate protection from his or her self or a caretaker.

4. The adult is unable to manage his or her personal, home or financial affairs in his or her own best interest and/or is in eminent danger to self or other(s) by failure or inability to act.

When the investigation is completed the social worker has his or her supervisor review the information and the assessment as to whether or not Protection Program services are required by the referred adult.

POLICY (continued)
5605

Investigation Outcome
5605.7

The six possible outcomes of a Protection Program investigation are:

a. Report Founded.

The reported incident of suspected adult neglect, abuse, exploitation or hazardous living situation was confirmed or verified by the Division's investigation and a protective case opened.

b. Report Unfounded, Adult Determined at Risk.

The reported incident of suspected adult neglect, abuse exploitation or hazardous living situation was not confirmed or verified by the Division's investigation, but the investigation did determine that the adult was in need of social services. This could result in opening a protective case or the adult voluntarily applying for services through the In-home Support program, or referral to community resources or no open case within the Division.

c. Report Founded, Resolved During Investigation.

This could mean that the reported incident was confirmed or verified; however, the investigation by the Division determined that the incident was not neglect or abuse. It could also mean that a reported incident was resolved to the Division's satisfaction during the investigation.

d. Report Founded, Adult Refuses Services.

Pertains to a reported incident of suspected adult neglect, abuse, exploitation or hazardous living situation which was confirmed and verified by the Division of Welfare's investigation and the adult has refused services and is considered competent.

e. Report Unfounded.

In the investigation of suspected abuse, neglect, exploitation of hazardous living situation it was determined that there was no probable cause to believe that neglect, abuse, exploitation or hazardous living situation has occured. In this outcome, no service case would be open within the Division of Welfare.

Appendix F

Criteria - Need for Protective Services

State of Alaska
Dept. of Health & Social Services
Division of Social Service Programs
Service Manual (APS)
Section 2.5

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2.5 ASSESSMENT

a. The purpose of the assessment is to determine the nature of the request for help, to identify the factors involved, and to document the circumstances of abuse, neglect or exploitation. See Guidebook 7.1.2, "Case Assessment".

b. SINCE THIS SERVICE IS PRIMARILY A RESPONSE TO A REQUEST FOR HELP FOR AN ADULT IN A CRISIS SITUATION THE ASSESSMENT/INVESTIGATION OF THE CIRCUMSTANCES OF THE ABUSE, NEGLECT OR EXPLOITATION SHALL BE COMPLETED WITHIN 14 WORKING DAYS FROM THE RECEIPT OF THE REQUEST OR REFERRAL.

c. CHILD/ADULT ABUSE, NEGLECT, EXPLOITATION FORMS SHALL BE COMPLETED ON ALL ADULT PROTECTIVE SERVICE CASES. THE FORM SHALL BE FILED IN THE CASE RECORD.

d. In evaluating and determining the need for Adult Protective Service, the following factors should be considered:

1. Mental, emotional status

A. Is the adult able to understand and be understood?

B. Does the adult appear or complain of unusual thinness, pallor, paralysis, tremors, speech difficulty, excessive fatigue, weakness, falling, dizziness, persistent pain, other physical symptoms?

C. Does the adult appear to be mentally alert, mentally retarded, mentally ill?

D. Does the adult have frequent or prolonged periods of depression, crying, apathy, feelings of persecution, excessive nervousness, irritability, explosive anger, other emotional symptoms?

E. Does the adult appear interested in dress, cleanliness, daily living activities, self?

F. Is the adult self-mutilating, threatening suicide, threatening physical harm to others?

G. Does the adult appear interested in or aware of the environment with which he must deal?

2. Environment (Living Situation)

   A. Is the adult lacking in provision of adequate food, shelter, clothing, access to medical care,, attention to personal and incidental needs by those responsible for his care?

   B. Are the adult's resources being managed to meet personal care, food, shelter, clothing needs by self or caretaker?

   C. Are personal care needs, daily living activities being met by self or caretaker, e.g., food preparation, laundry, shopping, cleaning?

   D. Is the living situation hazardous to health and safety of the adult, e.g., adequate light, potable water, safe plumbing and building structure; fire hazard due to debris, defective wiring?

3. Personal Relationships

   A. Does the adult have positive/negative relationship with friends/relatives? Are friends/relatives maintaining regular contact with the adult? Are friends/relatives assisting the adult? Knowing the adult's situation, are friends/relatives willing to assist further? Have others assisted the adult in the past and are they willing to assist again?

4. Medical and Safety Needs

   A. Is the adult able to manage personal care, medical care, financial and living needs independently?

   B. Is the adult being (or threatened with being) beaten, whipped, burned, having food intentionally withheld by those responsible for his care?

   C. Is the adult being (or threatened with being) chained, tied up or otherwise forcibly restrained by those responsible for his care?

   D. Are medical care needs being met by self or caretaker, i.e., arranging for medical care, getting to medical service resource(s), following through with medical recommendations?

Appendix G

Protective Services - Evaluation

State of Kentucky
Service Manual
Section .p. 22.600

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Investigation Policies and Procedures

P22.600 CRITERIA FOR EVALUATING THE ADULT BEING INVESTIGATED

The purpose of the investigation is to determine if the adult is in need of protective services or other services that may be available. In addition, it may be necessary to request a legal determination to adequately protect the client. In order for the social worker to make an adequate assessment of the needs of the adult, considerable information is necessary. The social worker may request assistance from appropriate resources within the Department, county health services, or other local resources.

The following outline includes areas that the social worker should consider in evaluating the adult. Depending upon the situation, nature and extent of the report, and the residence of the adult, some areas of the outline may not be applicable.

Protective Services Evaluation

A. Demographic Information
   (1) Name of adult; age; sex; race; social security number
   (2) Address of adult; county
   (3) Directions to home
   (4) Legal status of adult (committee, guardian, representative payee, power of attorney, etc.)
   (5) Name; address; relationship of person who is caretaker of adult.

B. Physical Environment of Adult
   (1) Neighborhood (describe)
   (2) Type of residence (home, trailer, alternate care facility, public housing, etc.)
   (3) Condition of residence (soundness, deteriorating, dilapidated, etc.)
   (4) Public utilities, private utilities (determine if residence has electricity, heat, water, toilet facilities, cooking facilities, refrigeration)
   (5) Food supply - food source - dietary habits (social worker should determine the following):

      (a) Does the adult's residence show physical presence of food? Is the food adequate?
      (b) Does the adult participate in any congregate meals or meals on wheels programs? Would the adult be interested if available? Is the adult eligible?

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P22.600 CRITERIA FOR EVALUATING THE ADULT BEING INVESTIGATED (Continued)

(c) Does the adult receive food stamps?
(d) Would the adult be interested in food stamps?
(e) Does the adult cook? How often? What kinds of food?

(6) Housekeeping

(a) Describe the ability of the adult to maintain the residence, if applicable.
(b) Is the client motivated to maintain the residence?

(7) Hazards

(a) Are hazardous conditions present?
(b) Does the adult have physical or mental conditions that create hazards for the adult?

(8) General observation, assessment, and notes concerning the physical environment of the adult.

C. Social Environment
(1) Is the adult isolated?
(2) Does the adult have relatives, friends, or others who visit?
(3) Are there other members of the residence of the adult?
(4) Describe and give relationship.
(5) Does the adult in alternate care socialize with others, have visitors, etc.?

D. Personal Appearance of the Adult
(1) Describe the personal appearance of the adult including how the individual dresses, the gait, posture, facial expressions, gestures, speech, coherence. Is the adult aware of the time, place, date, events, etc.?
(2) Assessment, observation, comments.

E. Physical Health of Adult
(1) Health problems defined by the client.
(2) Utilization of health services.

(a) Does adult have a physician?
(b) When was the adult last visit to a physician?
(c) What medication does the adult accept?

(3) Physical health problems of the adult.

(a) Hearing
(b) Vision
(c) Malnourishment
(d) Persistent cough
(e) Vomiting
(f) Shortness of breath
(g) Chest pains
(h) Open sores
(i) Sudden Weight Loss

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P22.600 CRITERIA FOR EVALUATING THE ADULT BEING INVESTIGATED (Continued)

(j) Change in bowel habits
(k) Blood in urine
(l) Lumps

(4) Is adult able to talk, communicate or aware of physical surroundings?

F. Mental Health of Adult
(1) Describe problems defined by adult.
(2) Has the adult experienced recent loss of spouse, family member, or close friend?
(3) Has the adult displayed recent or sudden behavioral changes, changes in habits, attitudes, etc.
(4) Does the adult have problems with alcohol or drugs?
(5) Does the adult have a history of past mental health problems?
(6) Does the adult have the capacity to consent?

G. Comments on physical and mental health (social worker observation of adult; follow-up areas indicated).

H. Adult Functioning
(1) Mobility of Adult -- The adult's mobility will range somewhere between the following: (social worker's comments)

(a) Bedridden
(b) Partially bedridden
(c) Wheelchair
(d) Housebound
(e) Able to get to yard
(f) Neighborhood
(g) Public transportation
(h) Drives car
(i) Other

Determine the degree of mobility of the adult.

(2) Physical competence of the adult -- The following series of items will assist the social worker in determining the competence of the adult in providing for himself.

(a) Feed self
(b) Bathe self
(c) Dress self
(d) Use toilet
(e) Get out of bed
(f) Do light housework
(g) Climb stairs
(h) Go outdoors
(i) Cook
(j) Shop
(k) Do heavy housework
(l) Go to church

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P22.600 CRITERIA FOR EVALUATING THE ADULT BEING INVESTIGATED (Continued)

(3) Social worker observation, notes, etc. on the adult's mobility.

I. Economic Situation of the Adult
(1) What is the adult's income; source?
(2) What other resources do they have?
(3) What expenses do they have?
(4) Does someone manage their fiduciary affairs?

In many situations, adults will disregard needed services rather than discuss in detail sources of income. The primary purpose of determining economic situation during the investigation is to seek any information that will assist the social worker in assessing the adult's need for protective services. Often the lack of adequate financial resources is a major contributing factor of the adult. The social worker should use extreme sensitivity in discussing sources of income and should only gather enough information to make an assessment of the adult's need for protective services.

J. List other persons or agencies involved with the adult. (Specify involvement)

K. What is the adult's perception of problems?

L. Social worker's assessment -- Based upon all information available, the social worker should make an assessment of the adult's need for protective services with recommended action for the future. The social worker, in addition to the above information, should include, but is not limited to, the following concerns:

(1) Is there a need for immediate medical examination by a physician to determine the degree of abuse or health neglect? Will the adult consent?
(2) Does the adult need referral for other health or mental health services, diagnosis, etc.?
(3) Have any known criminal laws been violated?
(4) Does the client have the ability to consent to services?
(5) Does the client appear to be incompetent?

M. Recommended action -- Social worker's recommendation for further action, along with future contacts with the adult and services that may assist the client.

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Appendix H

Client's Right to Self Determination

State of West Virginia
Service Manual - Nov. 1979
Section 29110

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29110 Client's Right to Self-Determination

The worker must continuously be aware of client's right to self-determination. The worker should guard against a judgmental attitude when viewing a client's situation and should be aware that the client has the right to live in the manner he chooses as long as he has not been determined incapable of decision making by the court during committee or guardianship proceedings. The client's choice to remain in his situation may be a cause for concern by friends, relatives or other interested parties. The worker may need to interpret to them the client's rights to self-determination and to his own life-style within the boundaries of the law.

At times, it may be difficult to serve both the client's interests and those of the community. The worker's primary role is to provide social services to and serve as advocate for the client. When necessary, the worker should strive to use his skills not as a means of social control of the individual, but to help the community develop better understanding and tolerance of the Protective Service client.

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Appendix I

Representative Payee

State of New York
Info. Memo : State Commr - SS
to District Commrs - SS
Page 8

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2. Social Security Procedures— Representative Payee

Local districts are familiar with the representative payee procedure and many are both initiating the process of securing designation of a representative payee and serving in this capacity. It is most frequently used by the local districts for persons in Adult Residential Care or Residential health care facilities and for those adults living in the community who require protective services.

a. Definition: A representative payee is a person approved by the Social Security Administration to receive benefits on behalf of an eligible person when there is positive legal, medical or other acceptable evidence presented which establishes that the beneficiary is unable to manage his assets or protect his interests by reason of physical or mental impairment.

There has been some confusion about "other acceptable evidence". When medical or legal evidence is not available, "other acceptable evidence" has been interpreted to mean evidence as obtained from social agencies, professional and lay persons regarding the persons incapacity. Thus such evidence, i.e. facts and information obtained in a district's assessment of a case, can serve as a basis for a determination by the Social Security Administration District Office. This interpretation of Social Security policies is addressed in their Program Guide #77-4 dated 5/12/77.

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Appendix J

Case Planning

State of Alaska
Dept. of Health & Social Services
Division of Social Service Programs
Service Manual (APS)
Chapter: Intake - Sects. 2.6 & 2.7

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2.6 CASE PLANNING

a. Consider the client's willingness to change, as well as the willingness of other significant people involved in the situation.

b. You will need to determine what services are needed, and which are available in the community to assist the client, e.g., meals on wheels.

c. Consider the advantages and disadvantages of different helping methods and procedures for a particular situation.

d. Explain to the client what services are available to meet his needs.

e. Plan with the client to determine what he thinks will best meet his needs.

f. If no appropriate resources are available through the use of I&R, plan with the client what help the Division can provide, i.e., supportive counseling and guidance, or homemaker support.

g. Determine goals to be achieved and mutually set up time frames.

h. See Guidebook 7.13, "Case Planning."

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Appendix K

Service Planning - Needs Assessment

State of Nebraska
Public Welfare Manual (draft) Dtd: 10/16/80
Sect. 1395.06

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-1395.06 SERVICE PLANNING: The service worker shall initiate Service Planning by conducting a needs assessment.

To conduct the needs assessment, the service worker shall determine the following information by interviews with the client and through other sources as well as by observation of the client:

1. The environmental hazards in relation to the alleged abuse/neglected adult's needs.

2. The alleged abused/neglected adult's functioning in his/her environment.

   a. The adult's capacity to provide for personal needs, e.g., adequate food, shelter, clothing, etc.
   b. The adult's need for medical treatment, his/her understanding of the need for medical treatment and his/her capacity to consent to and obtain medical treatment
   c. The adult's ability to manage household tasks, when appropriate
   d. The adequacy of housing
   e. Whether the adult has sufficient income to meet his/her needs
   f. The adult's ability to manage his/her income
   g. The adult's ability to interact with others without endangering him/herself or others
   h. The adult's ability to control his/her own behavior so as not to endanger him/herself
   i. The adult's need for legal protection (guardianship, conservatorship, mental health commitment) and/or other legal services
   j. The adult's willingness to accept non-legal assistance, such as voluntary mental health treatment or power of attorney.

3. When appropriate, the caretaker's ability to provide care and protection for the alleged abused/neglected adult:

   a. To provide for the adult's personal needs
   b. To interact with the adult without endangering or threatening the adult's physical being or property

4. The adult's need for supportive services and/or information and referral and his understanding of the need for services

5. What action is necessary to enhance the adult's self-sufficiency and at the same time protect the adult. This may be determined by evaluating:

   a. The specific problems relating to care/protection of the alleged abused/neglected adult
   b. Possible approaches to solving these problems
   c. The adult's and/or caretaker's capacity and motivation to deal with these problems
   d. Positive and negative factors in the environment
   e. The internal strengths and weaknesses of the adult
   f. Specific goals for improved care/protection of the adult
   g. Decisions about which services will be provided, how and by whom, including referral to other community services and mobilization of the adult's resources.

The needs assessment shall be recorded in the case record and a determination of case status made [Handbook 1395.04 a (3)].

Appendix L

Case Managment - Services

State of Kansas
Services for Adults
Manual S.V. (dtd) 7/1/78
Sect. 5022

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5022 Case Management Services

Case Management Services includes all tasks performed in behalf of clients, by SRS social service workers, to assist them in obtaining needed help from SRS or other community resources. Case management is an integral part of all services provided through SRS.

Tasks of Social Service Workers

A. Intake of information for eligibility determination.

B. Determination of eligibility by an analysis of information obtained from application, applicant and other significant persons.

C. Coordinate service delivery with other agency staff and other community resource agencies.

D. Review and edit social service plans, reports, documents, billing forms regarding total case load.

E. Complete and submit daily, monthly, quarterly and special reports, time studies, research studies.

F. Review and analyze reports, printouts, etc.

G. Reassess the client's financial and personal need for services.

H. Monitor/evaluate purchased services to determine:
   1. If the client is receiving quality and quantity of services according to the individual plan and purchase agreement.
   2. If vendor agency is in compliance with certification regulations.

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Appendix M

Case Managment - Process

State of Alaska
Dept of Health & Social Services
Division of Social Services
Program Manual
Sections . 3.0, 3.1, 3.2,3.3,3.4,

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3.0 CASE MANAGEMENT

3.1 CASE MANAGEMENT WHEN OTHER RESOURCES ARE BEING UTILIZED

a. If resources are available to help resolve the adult's problems, the social service worker should determine which resources would best meet the client's needs and provide information and referral and follow-up. This may take the form of:

   1. assisting the client in seeking appropriate legal counsel, referral to appropriate advocacy groups, or assistance in utilization of consumer protection resources;

   2. providing information about and referral or arranging for provision of other appropriate services for adults who for reasons of neglect, abuse, or exploitation cannot be reunited with their families: and/or

   3. assistance in arranging for concerned, responsible individuals to act when necessary on the client's behalf;

   4. assisting the client to secure benefits, assets and entitlements such as Social Security, veteran's benefits, medicaid or food stamps;

   5. preventing wasting of the client's resources;

   6. utilizing the client's resources to provide the client with adequate food, shelter and clothing; and

   7. enlisting the help of interested friends and relatives.

b. If the social service worker is providing I & R he will need to check with the referral source to determine whether or not the client has been served. If not, he should determine the reasons why and re-evaluate the appropriateness of the referral. Provision of transportation may be indicated.

3.2 CASE MANAGEMENT WHEN CASEWORK HELP IS BEING PROVIDED

a. Casework should be goal oriented to address the problems which have been identified.

b. With the adult's permission, the social service worker will involve significant others who are related to the adult's problem together with or separate from the client.

3.3 CASE MANAGEMENT WHEN HOMEMAKER SUPPORT IS BEING PROVIDED

Homemaker support is provided in order to meet particular goals.

a. Monitoring homemaker support activities involves periodic contact with both the homemaker or, if appropriate, the contractor's regional supervisor and the client to determine the progress being made toward the goals and whether the goals continue to be appropriate.

b. Modification may need to be made in the activities of the homemaker.

c. The client should be urged to assume as much responsibility for his care as possible.

d. Dependency on a homemaker should be minimized.

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3.4 CASE REVIEW

a. A WRITTEN CASE REVIEW SHALL BE COMPLETED ON A QUARTERLY BASIS AND SUPERVISORY APPROVAL SHALL BE OBTAINED. See Guidebook 7.2.2, "Case Review".

b. THE NEED AND THE CIRCUMSTANCES OF ABUSE, NEGLECT AND EXPLOITATION SHALL BE REDOCUMENTED EVERY SIX MONTHS AT WHICH TIME A NEW "CHILD/ADULT ABUSE, NEGLECT, EXPLOITATION FORM" WILL NEED TO BE COMPLETED AND FILED IN THE CASE RECORD AND FORM 1 GREEN WILL NEED TO BE SUBMITTED.

c. A WRITTEN CASE REVIEW SHALL BE COMPLETED EACH TIME THERE IS A CHANGE IN THE AMOUNT OF HOMEMAKER SUPPORT BEING PROVIDED. See Guidebook 7.2.5, "Written Case Review".

d. WHENEVER HOMEMAKER SUPPORT IS BEING REDUCED THE CLIENT SHALL BE SENT A MANUAL NOTICE OF FINDING/FAIR HEARING. (A NOTICE WILL BE ISSUED BY THE COMPUTER IF HOMEMAKER SUPPORT IS DISCONTINUED.)

e. See Guidebook 6.2.2 - 6.2.6.

f. The Social Service Plan (Form 1 Green) must be updated:

   1. Every time there is a change in the case requiring an update (change of address; housing situation; service or support activity).

   2. Every three months if a support activity is open (e.g., Homemaker).

   3. Every six months if only APS is open. (Notice of Finding will be sent by computer.)

   4. Any increase or decrease will require a new "Authorization and Invoice" form (back of Form 1) to be completed. (For reduction in homemaker support use manually issued Form 1.) See Guidebook 6.0, "Notice of Finding/Fair Hearing.

g. Any change in the nature of the homemaker support (i.e., different days; different duties) will require notifying the contractor's regional supervisor.

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Appendix N

Criteria for Assessing Abuse, Neglect and Exploitation

State of Kentucky
Service Manual
Investigative Policies & Procedures
Sect. p. 22.540

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22.540 CRITERIA FOR ASSESSING POSSIBLE ABUSE, NEGLECT, OR EXPLOITATION (Continued)

Investigation of abuse, neglect, or exploitation relies upon good casework skills of the social worker, training and assistance from the Bureau's supervisory staff. Prior to the investigation, staff should attempt to determine if the report is routine or if it presents special consideration.

Routine Reports

Routine reports are those reports that address possible abuse, neglect, or exploitation of an adult. Included are the following:

(1) Physical Abuse -- An adult is subjected to pain, injury (non-accidental), or mental anguish by others. An adult subjected to hostile treatment by others frequently evidences an unusual number of bruises, welts, or broken bones.

(2) Sexual Abuse -- Sexual abuse or sexual exploitation may be difficult to detect upon sight. Generally speaking, sexual abuse may be more frequent among younger adults, the mentally retarded or the disabled. The infliction of sexual abuse may include incidents of forced prostitution. Social workers should be advised that when other criminal laws are violated, the local law enforcement agency should be contacted.

(3) Neglect -- Generally speaking, neglect is of two types: neglect by a caretaker and self-neglect.

(4) Exploitation -- Exploitation by statute refers only to misuse by a caretaker of governmental funds intended for the use or care of the adult. There are a number of other areas in which an adult can be exploited such as sexual exploitation, forced labor, misuse of drugs, etc., but the majority of these situations would be covered under the definition of abuse/neglect in the statute.

Reports of a Special or Problematic Nature

The Bureau may receive reports that vary from the routine due to special circumstances or living arrangements.

(1) Spouse Beating -- In most cases, spouse beating would not be included under the Kentucky Adult Protection Act; however, if the spouse being abused meets the statutory definition of an adult, the social worker will proceed with the investigation. In all cases, the person making the report should be encouraged to contact the local law enforcement agency.

(2) Reports of a Questionable Nature -- The Bureau may receive reports of possible abused, neglected, or exploited adults generally known to the community which they feel are unsubstantiated. Nevertheless, the Bureau

	Investigation Policies and Procedures
Reports of a Special or Problematic Nature (continued)	is obligated to initiate an investiongation involving any adult meeting the statutory definition. Any other reports of special or problematic nature should be immediately brought to the attention of the Social Service Supervisor for instruction and guidance.

Appendix O

Complaint Investigation - Long Term Care Facilities
Adult Family Homes, Rooming Houses,
Boarding Homes and Individual
Adult Living Arrangements.

State of South Dakota
Office of Aging
Manual (draft)
Long Term Care Protective Services (Sept '79)
Pages 5 - 12

Adult Family Homes, Rooming Houses,
Boarding Homes and Individual
Adult Living Arrangements.

State of Nebraska
Department of Public Welfare
Public Welfare Manual
Section 1395.0401

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3. Complete the SS-230. In complaints relating to a facility, where a specific client is not identified open a "John Doe" case file. Do not open case files using the facility as the primary client.

4. Investigate the complaint, obtain signed DHD/CS4A "Authorization for Release of Information" from the primary client, when possible. When not possible, have the responsible relative sign the DHD-CS4A.

Complaints Concerning Out-of-State Facilities

When a complaint is received concerning an out-of-state facility; pertinent information should be taken and the complaint referred to the Long-Term Care Ombudsman Program in the appropriate state. (See Appendix)

Analysis of Complaint as a Preliminary Step to Investigation

Once a complaint is received it is important to establish the following five objectives:

1. To categorize the complaint.
2. To identify those persons involved.
3. To identify relevant agencies.
4. To identify actions already taken by the complainant.
5. To identify information gaps that might require research.

Preparation for an Investigation

Investigation is the process by which complaints are substantiated or not substantiated. This process attempts to establish in a clear and concise manner (1) what has happened; (2) why it has happened; (3) who or what has the ability to resolve the problem; and (4) what the possible solution might be.

Investigating Complaints

The purpose of the following will be to explain how an investigation should be conducted. Investigation is the process by which the assigned worker verifies or substantiates, or does not verify or substantiate, the charges of the complaint. This process attempts to establish, as clearly as possible, what happened, why it has happened, who or what is responsible and possible solutions to the problem.

In the following paragraphs, the basic steps to follow when investigating complaints will be discussed.

1. Get a clear statement of the problem. Contact the person who made the complaint, if you did not receive the information directly. Try to get as many facts as possible. Be sure that you have clearly defined the problem and the problem is mutually understood by you and the complainant (the person who made the complaint). For instance, the complainant may give many details on various medical or family problems, when the real reason why he or she called was to get help in getting a nursing home bill straightened out. Try to clarify exactly what the complainant wants help with.

   Be aware of how the complainant's physical, mental and emotional condition can affect or relate to the problem. Some of the more seriously ill nursing home residents may be taking medication which could affect their thinking processes. Also, there may be complainants with severe memory lapses, paralyzing fears of retribution from facility staff, or a very weak understanding of their own problems. It is frequently necessary to assist the complainant in stating and clarifying the problem. However, try to remain unbiased. Be an objective evaluator. Do not assume that the complaint is valid or the resident is too ill to know what (s)he is talking about without a thorough investigation into all the facts of the complaint.

2. Review your information and organize a strategy for investigating the complaint. First, you should try to analyze the complaint. A complaint may involve several problems. List the problems in order with the most important problems first. Below is a complaint which illustrates this priniciple:

   Mr. Davis, aged 72, had recently been discharged from a local hospital but continued to require skilled nursing care which could only be provided by a nursing home. Mr. Davis' daughter understood from the doctor that her father would be in the home from three to six months after which he would be well enough to return home and, with her assistance, have little difficulty remaining there. However, after four months in the nursing home, Mrs. Smith had observed a tremendous weight loss affecting her father. She had been advised that (1) her father had been placed on an improper diet and, as a result, had lost too much weight. The complainant also stated that (2) her father was rarely seen by his doctor, and (3) was constantly missing clothing despite the fact that the family did his laundry. It was also the case that the (4) daughter felt she was being overcharged for her father's care, especially for oxygen. She had requested and received an itemized billing which she would forward to the social worker;

   First rank the problems in order of importance.

   A. Mr. Davis may have been placed on an improper diet causing a severe weight loss.

B. His doctor might not be examining him often enough.

C. His clothing has been missing constantly.

D. The charges for services my be inflated, expecially for oxygen.

Second, find out any other persons or agencies who may be involved in this problem. Find out any action the other persons or agencies may have taken to resolve this complaint. Using the complaint example, some questions the investigator might ask Mr. Davis' daughter are:

A. Did you discuss the problem with the nursing home administrator, director of nurses or charge nurse? Have you taken your problem anywhere else?

B. Who is your father's doctor?

C. How often has the doctor seen your father since he entered the nursing home?

D. Who told you that your father was placed on an improper diet?

E. Do you have any other records which might help us? (i.e., a listing of your father's clothing)

Third, identify information gaps that will require investigation. For instance, the complaint described above would require a review of hospital and nursing home medical records; a review of menus as well as unannounced visits at the patient's meal times; a review of the daughter's clothing list and a comparison of this list to Mr. Davis' existing clothing supply; and a review of the nursing home bills.

Fourth, determine which problem areas you are competent to investigate and enlist the help of experts in dealing with the other areas. For instance, the review of medical records may best be done by a physician or a nurse. You may want to contact the physician or nurse on the Medical Review Team for assistance if the complaint involves a patient's

medical care and treatment.

Fifth, plan your investigation. Determine what regulations, contracts or records you need to review. Determine whom you need to interview to get more information. Decide what you need to observe when you visit the nursing home. Try to consider every detail and maintain objectivity.

3. Observe the nursing home setting relevant to the complaint. Visit the nursing home unannounced and use the sense of sight, hearing, smell, taste and feel of objectively observe conditions in the nursing home. The following are some common complaint areas and things to look for when investigating the complaint:

   A. Dietary Complaints:

      Arrive at the home just prior to mealtime during the preparation of the food and the transfer of the food onto the trays.

      1. Ask to see the menu for the week. (Daily menus should be posted).
      2. Compare what was actually being served with what was scheduled to be served.
      3. Ask for a copy of the client's special diet.
      4. Request examples of their menus.
      5. Compare general menus with special menus.
      6. Watch how special diets are dished up and segregated for delivery to the right patient.
      7. Observe the quality and quantity of food served.
      8. Find out if snacks are served.
      9. Watch the delivery of meals to non-ambulatory or bed-ridden patients.
      10. Note what devices are used to maintain proper temperature at the time food is served.
      11. Find out how many staff are assigned to the food services.
      12. Check on the amount of assistance given to those patients who are unable to feed themselves.
      13. Find out how much time is allowed for the meal before trays are collected.

14. Notice how much food is brought back to the kitchen. Is a record made of the quantity of food returned?

15. Do the charge nurse or aides report patients not eating?

16. Is the charge nurse supervising the distribution of trays?

17. Is assistance given when needed?

B. Insufficient Care or Neglect:

1. Does the air smell strongly of cover-up deodorizers and sanitizers? Are there strong urine smells? This could indicate lack of attention by staff.

2. Does the patient's skin feel dry and his lips appear dry and cracked? This could be a sign of dehydration. Are there water containers within the patient's reach? Is the water fresh? Are water glasses available?

3. Are the patient's fingernails cut and clean?

4. When you talk with the patient, does his breath smell bad? This could indicate poor mouth care and inattention by staff. Do dentures appear dirty or stained?

5. Are the patients clean and tidy?

6. Are clothes clean and tidy?

7. Are patient's call lights left unattended? Do they work?

8. Are there skin irritations or bed sores (decubeti)? These could indicate that the patients are not moved or turned frequently enough.

9. Are bed linens clean? Are patients left in wet beds?

10. Note the use of wheelchairs, catheters, neck braces, walkers, artificial limbs (prosthetic devices) and retraints. Are they provided where necessary? Are restraints used unnecessarily? Are they tied to tight or left on too long?

11. Do patients appear cold and shivering?

12. Do staff talk pleasantly with patients?

13. Are the rooms properly ventilated and appropriately lighted? Is the humidity kept at a comfortable level?

Please note that the social worker is not in the business of diagnosing patients or passing judgment on quality of medical or nursing care. Rather, they should be looking for indicators of poor personal care or conditions which suggest the need for assessment by the physician or

nurse from the Medical Review Team or State Health Department.

C. Unsafe Conditions

Carefully look at the physical condition of the home and see if it has the following safety features:

1. A functioning sprinkler system, dependent on type of construction,
2. Unlocked exit doors,
3. Functioning fire extinguishers,
4. Fire escapes and ramps wide enough for wheelchairs,
5. Unobstructed corridors wide enough for wheelchairs,
6. Handrails in corridors,
7. Grip bars next to bath tubs, toilets and in showers,
8. Safety mats or grip strips in showers and tubs,
9. Side rails on beds,
10. Call buttons or pull cords within the patients reach,
11. Flush thresholds at doorways,
12. Adequate hall lighting day and night,
13. Well-marked exits,
14. Emergency lights pointing to exits,
15. Posted smoking rules enforced.

During an investigation, the social worker must temper his or her observations with an understanding of the implications of his intrusion into the setting which he intends to observe. The social worker should try to minimize his effects on that setting by careful timing of his visit and firm control over his own informational inputs. Any attempts by administrators to cover up or evade issues should be noted.

Questions should be designed to net specific bits of information. Try not to include or imply in the questions any evaluation of what is

observed. Finally, do not react to what is observed, thus withholding that information which could most easily affect the setting, i.e., don't show approval or censure of any particular occurrence. However, secure relief or help immediately when needed.

4. Interview the nursing home staff, the administrator and/or any other persons who could provide information regarding the complaint. The interview should begin with the social worker introducing himself or herself and explaining the purpose and functions of the visit. Explain what you want to know and why you want to know it. Unless there is some very important reason for being less than candid (perhaps maintaining the complainant's anonymity), the specific goal of the interview should be explained.

The social worker investigating the complaint should then direct the pattern of the conversation with his questions. The questions should help the person talk, relieve anxiety and clear up confusion. Also, the social worker should review the facility contract, the patient's bill, the statement of the patient's personal account, the patient's medical records or any information relevant to the complaint at the time. When receiving confidential materials, as mentioned above, be certain to present a signed DHD/CS4A, Authorization to Obtain Information, which allows the social worker to do such reviewing. Try to distinguish between fact and fiction, sorting out in the investigative interview facts, heresay, characterization, evaluation and opinion. For example, when a patient is described as "uncooperative," the interviewer should ask for specific uncooperative behaviors the patient exhibits (when, how often, with what people, etc).

At the close of the interview, the social worker should explain what he intends to do with the information he has received and what, if any, future involvement the person being interviewed can expect.

Please note that the facility administrator or, in his (her) absence, the next responsible individual i.e., the Director of Nursing, should be interviewed in every complaint investigation. (S)He may not be aware of every problem in his (her) nursing home and may not be able to provide information. However, (s)he should be included in each investigation for the following reasons:

1. As a matter of courtesy.

2. To solicit his (her) support and understanding which can help in dealing with personnel in the home.

3. To seek the administrator's assistance in identifying individuals who can contribute information regarding this case.

4. (S)He is ultimately responsible.

5. To develop and maintain a relationship with the administrator which may be useful in future work.

5. Assess the information you have received. Try to gather enough information to answer any questions you may have concerning the problem or problems described in the complaint statement. You may need to review State regulations, get additional information from the facility or patient, or consult agency staff for information.

   If the complaint is verified, proceed to the resolution phase of the complaint process described in the following section.

Complaint Resolution Process

When a complaint is identified the resolution process begins. The resolution process attempts to implement one or more possible solutions and develop a procedure that will prevent similar problems from reoccuring.

The steps involved in resolving a complaint will vary with the nature and extent of the problem, the authority and resources of the program, the relationship of the program to standards enforcement agencies, and the degree of acceptance of the resolution by the complainant.

Resolution is the final stage of the complaint process when a complaint is resolved, the circumstances which caused the complaint no longer exist. Resolution is the ultimate goal of the complaint process, however, there are factors which must be recognized and respected in pursuit of that goal.

A. Not every complaint can be resolved. What are continuing and often times frustrating problems are those complaints which by their nature are unresolveable. One such complaint could be as follows: The widow of a recently deceased patient reports that the patient, as a matter of course, had been allowed to wander unattended throughout the home. One night, while the aides and other staff members were playing cards in the basement lounge, the patient walked away from the facility. It was the middle of winter and the patient was not dressed adequately enough for cold weather.

-1395.0401 COMPLAINTS OF SUSPECTED ABUSE/NEGLECT OCCURRING IN HOSPITALS, STATE REGIONAL CENTERS, LICENSED NURSING HOMES, CENTERS FOR THE DEVELOPMENTALLY DISABLED, ALCOHOL/DRUG REHABILITATION CENTER/HALF-WAY HOUSES, CUSTODIAL FOSTER HOMES AND BOARDING HOMES FOR THE AGED: The local service unit shall refer immediately all complaints of abuse/neglect occurring in the preceeding facilities to the appropriate law enforcement agency and to the Department of Health for their investigation. When the Department of Health is notified of a complaint of alleged abuse/neglect, the local service unit shall indicate whether the complaint has already been referred to a law enforcement agency. The Department of Health must receive written documentation of the complaint before they can take any action. If requested the local service unit shall cooperate with the Department of Health in the investigation.

After the investigation is completed, the local service unit shall contact the Department of Health and/or the law enforcement agency to determine the status of the investigation and subsequent actions taken. The local service unit shall send to the State Central Register, Form SS-60 "Adult Abuse/Neglect Report" within 60 days after receipt of the complaint.

-1395.0402 COMPLAINTS OF SUSPECTED ABUSE/NEGLECT OCCURRING IN ADULT FAMILY HOMES, ROOMING HOUSES, AND BOARDING HOUSES: The local service unit shall conduct an investigation and carry out all case management and direct service activities as are appropriate on each complaint received in accordance with the policies and procedures contained in Handbook Section 1390ff.

When appropriate, the local service unit shall request State Fire Marshal and Department of Health inspections of the facilities in question.

Upon completion of the investigation, the local service unit shall send a written report to the following:

1. Services workers within the local service unit responsible for resource development of Adult Family Homes, or
2. Department of Agriculture, Division of Dairies, Foods and Drugs for rooming, or boarding houses, and
3. State Central Register.

The local service unit shall refer cases of suspected abuse/neglect involving alternate care facilities owned or operated by any employee of the Department of Public Welfare to the appropriate law enforcement agency immediately. In all these cases a third party (e.g., the appropriate law enforcement agency) shall conduct the investigation. Under no circumstances shall the Department of Public Welfare staff solely conduct such an investigation.

-1395.05 INTAKE: When the local service unit receives a referral of a complaint of alleged abuse/neglect of an adult from the Abuse/Neglect Hotline, law enforcement agency or another source the services worker shall -

1. Contact the alleged abused/neglected adult and interested individuals, if any (e.g. caretaker, guardian, or relative),as soon as possible. The worker shall conduct in-person visits to the home of the alleged abused/neglected adult whenever possible and feasible. The worker shall make in-person contact immediately on all cases where imminent danger to the adult's life, health, or safety is indicated.

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2. Determine if emergency intervention is needed.

   a. When there is reason to suspect that the adult -

      (1) Cannot permit entry into his/her home because s/he is too ill or too injured to do so, or the alleged perpetrator prevents entry; or
      (2) Refuses entry and is dangerous to himself/herself or to others,

      the services worker shall contact the law enforcement agency or the county attorney:

      (3) To request the county attorney's recommendations as to subsequent actions; and
      (4) To request law enforcement assistance to enter the adult's home.

   b. When the services worker determines the adult is -

      (1) In immediate danger and requires medical treatment; and
      (2) Unable to consent to medical treatment, or unwilling to consent to medical treatment,

      the service worker shall contact -

      (3) the appropriate law enforcement agency and/or the county attorney immediately to request assistance in obtaining medical care for the adult; or
      (4) an attorney to petition the county court to exercise the power of temporary guardian to order medical treatment.

3. Determine whether the complaint is unfounded (see Handbook 1395.08 #5) or whether further investigation is required.

   a. When the report is unfounded the services worker shall -

      (1) Send a written report of findings to the appropriate law enforcement agency as required by Nebraska Statutes 28-713, R.R.S. 1979. A copy of Form SS-60 "Adult Abuse/ Neglect Report", or a narrative may be used to fulfill this requirement;

      (2) Explain available social services to the adult if s/he has identified needs; and

      (3) Report investigation time (if a service case is not opened) directly on Form DSS-58 "Service Billing Document" as "Protective Services Investigation", Code 1590 (see Handbook 1395.19).

   b. When further investigation is required the services worker shall -

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(1) Open a service case, if sufficient information is available, by completing a Form DSS-3A "Social Service Application". If a service case is not opened, the services worker shall report investigation time directly on Form DSS-58 as code 1590, (see Handbook 1395.19);
(2) Initiate service planning (Handbook 1395.07);
(3) Complete Form DSS-4 "Case Information Summary" indicating protective services and other appropriate services;
(4) Complete Form DSS-4A "Social Service Provider Authorization", authorizing "Protective Services Investigation" (Code 1590) and other appropriate services; and
(5) Submit a written report of findings to the appropriate law enforcement agency (see Handbook 1395.05 3a(1)).

4. Send Form SS-60, "Adult Abuse/Neglect Report", to the State Central Register within 60 days after receipt of the referral.

-1395.06 INVESTIGATION: Within 60 days after the receipt of the complaint, the services worker shall complete the investigation. To conduct the investigation, the services worker shall -

1. Visit the home of the alleged abused/neglected adult whenever possible and feasible. In-person contact shall be made on all cases where imminent danger to the adult's life, health, or safety is indicated. The services worker shall determine whether any immediate action is needed to protect the adult.

2. Interview the alleged abused/neglected adult in order to obtain his/her explanation of the incident(s) alleged in the complaint.

3. Interview other individuals involved in the situation, if any, in order to obtain their explanations of the incident(s) alleged in the complaint. The service worker shall determine who is apparently responsible for the alleged abuse/neglect.

4. Contact and interview interested individuals (e.g., guardians, caretakers, and relatives), when appropriate, to determine their interest in and degree of support (e.g., care and protection) they can provide to the alleged abused/neglected adult.

5. Contact other sources of information, including the complainant, landlord, neighbor, physician, hospital staff, law enforcement, as needed to determine facts about the nature and cause of the alleged abuse/neglect.

6. Observe, assess, and document the safety and condition of the home environment of the alleged abused/neglected adult -

   (1) Adequacy of his/her housing; and
   (2) Environmental hazards.

7. Observe, assess, and document the alleged abused/neglected adult's functioning in his/her environment as demonstrated by his/her -

   (1) Understanding of any dangers and need for protective/corrective action.

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(2) Ability to provide for adequate shelter, clothing, and food.
(3) Need for medical treatment and ability to procure and/or consent to such treatment.
(4) Financial situation (sufficient income, money management ability, etc.)
(5) Ability to manage household tasks.
(6) Ability to interact with others. (e.g., whether s/he endangers or threatens others' property/physical being, exhibits inappropriate behaviors).
(7) Ability to control own behavior so as to not harm himself/herself.
(8) Need for legal services such as guardianship and mental health commitment.
(9) Willingness to accept non-legal assistance such as voluntary mental health treatment or social services.

8. Request State Fire Marshall and Department of Health inspections of the adult's living arrangement, as appropriate, when the adult's living arrangements present a hazard.

9. Initiate service planning (see Handbook 1395.07) if the investigation indicates actual harm or potential threat of harm to the alleged abused/neglected adult.

10. Send a written report of findings to the appropriate law enforcement agency as required by Sec. 28-713, R.R.S. 1979 upon completion of the investigation. A copy of Form SS-60 or a narrative may be used to fulfill this requirement.

-1395.07 SERVICE PLANNING: When service planning is appropriate, the services worker shall complete the service plan within 60 days of the receipt of the complaint. The worker shall report all activities related to "Service Planning" on Form DSS-58 "Service Billing Document" using Code 1502. In order to initiate service planning the services worker shall -

1. Determine what action is necessary to enhance the adult's self-sufficiency and at the same time protect him/her. This may be determined by evaluating the -

   a. Specific problems relating to care/protection of the adult;
   b. Positive and negative factors in the environment;
   c. Strengths and weaknesses of the adult;
   d. Adult's and/or others' capacity and motivation to deal with these problems;
   e. Possible approaches to solving these problems;
   f. Specific goals for improved care/protection of the adult; and
   g. Decisions about which services will be provided, how and by whom, including referral to other community services and mobilization of the adult's resources.

2. Determine whether "Arranging for Legal Services" (see Handbook 1395.09) is needed.

3. Discuss the findings of the investigation and needs assessment with the adult and his/her legal guardian, if any.

4. Explain to the adult and his/her legal guardian, if any, the services which are available through the local service unit and other community services resources.

5. Obtain acceptance of services from the adult or his/her legal guardian, if any, if case management services from the local service unit are to continue beyond 60 days. The adult's or his/her legal guardian's signature on Form DSS-3A, "Social Service Application," documents acceptance of services.

   a. If the adult or his/her legal guardian accepts service, the services worker shall -

      (1) Develop a service plan with the client, utilizing shared decision making, as appropriate; and
      (2) Develop a contract based on the service plan which states the goals, priorities, and the time-frame that the client will be working toward. Part of the case management responsibility shall involve a continuous evaluation of the priorities and goals of the contract and an assessment of the client's progress in accomplishing these goals. When possible, the client and services worker shall sign the contract.

   b. If the adult or his/her legal guardian does not accept service, the worker shall terminate the protective service authorization (protective services may not be provided beyond a 60 day period without acceptance of services by the adult or his/her legal guardian unless court action has been initiated within the 60 day period). If, at any time, during the 60 day period the adult or his/her legal guardian willingly accepts services, a Form DSS-3A must be completed and signed.

-1395.08 DETERMINATION OF CASE STATUS: Within 60 days after the receipt of the complaint, the local service unit shall complete the investigation, complete any necessary service planning, and make a determination of case status.

At this time, the services worker shall complete Form SS-60, "Adult Abuse/Neglect Report", identifying the case status as one of the following:

1. Court Substantiated - when a guardian or a conservator is appointed by a court, when a client is committed by a county mental health board, or when the alleged perpetrator is found guilty or pleads guilty to charges stemming from the alleged abuse/neglect.

2. Petition to be Filed - when the services worker determines that the best interest of the client would be served by guardianship, conservatorship, or mental health commitment, and has requested that an attorney file a petition for guardianship, conservatorship, or mental health commitment.

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Appendix P

Referral Policy

State of Louisiana
Service Manual - 8/11/77
Sect. 13.835

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13-835 PROVISION OF PROTECTIVE SERVICES

This Section is not intended to be inclusive in relation to the provision of protective services to individuals harmed or threatened with harm. Instead the information is intended to provide general guidelines for service workers who are responsible for investigating referrals and providing protective services. Most referrals brought to the attention of the OFS will represent one of the following situations:

A. Services Requested by the Individual or by a Third Party with the Knowledge and Consent of the Individual

This will represent the most prevalent type of referral. "Third Party" refers to relatives, friends, concerned persons, or representatives of a social or other agency in the community who may be working with the individual or have knowledge of his condition. In these situations the worker shall conduct the investigation and provide needed services with the cooperation of the individual.

B. Services Requested by a Third Party Without the Knowledge and Consent of the Individual

The worker must enlist the individual's consent in order to complete an eligibility determination and to provide services. When the individual cooperates in the investigation, the worker may proceed to establish eligibility and to provide the needed services.

If the individual is not cooperative in the investigation or does not agree that there is a need for services, the worker is subject to the restrictions as detailed in Section 13-845.

C. Services Requested by a Third Party, but the Individual is Unable to Participate in the Investigation, and/or is Unable to give Consent for and/or Agree with the Provision of Services

The most common examples of this situation are individuals who are stroke victims, are comatose, or are disoriented in relation to their surroundings. Investigations of such referrals may be freely conducted if the service worker enters the individual's residence with the consent of a

third party who has authority to give consent for entry. A relative or other person who resides in the home would ordinarily be able to give consent for entry. The provision of services to individuals in these situations is limited to the restrictions detailed in Section 13-845.

D. Services Requested by, or in Behalf of, an Individual when a Third Party is Reported to be Neglecting, Maltreating, or Wasting the Resources of the Individual, of Depriving the Individual of Entitlements

In these investigations, the worker must be mindful of the fact that if the report is correct the third party will more than likely not be cooperative. The worker must also be aware that not all reports of this nature are valid. If the worker is unable to conduct an investigation of the report, the individual requesting services or the person initiating the referral should be advised to report the situation to a law enforcement or other appropriate agency in the community. Refer to Section 13-840.

Appendix Q

Service Tasks - Use of Other Resources

State of Kansas
Service for Adults
Manual
Section V - Part 5025

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Section V — Social Services for Adults — 7-1-78

5025 Resource Development Services

Resource Development Services are those activities performed by SRS staff which assist in the development, maintenance and availability of needed services within the state.

Tasks of SRS Staff

A. Collect data to identify unmet service needs of adults in your SRS Area.

B. Provide facts to community groups, local citizens, etc. regarding availability of services and service needs.

C. Recruit and mobilize potential service providers to develop service agencies and obtain funding.

D. Explain the role of Donated Funds in expanding service availability through SRS and provide assistance to community groups in soliciting and obtaining funds from prospective donors.

E. Coordinate available services in the community.

F. Provide technical assistance to purchase of service providers (vendors) regarding purchase of service applications, contracts and program certification.

G. Review, evaluate, submit recommendations regarding purchase of service applications.

H. Monitor/assess service programs of vendor agencies according to certification and contract requirements (see Purchase of Service Handbook and Licensing/ Certification Regulations).

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Appendix R

Incompetency - Standard of Measurement

State of Florida
HRS Manual - Aging & Adult Services
Adult Abuse & Neglect Proceedures
HRSM 140 - 2 p. 1-9 (See footnote Ch. IV)

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x. Functional Classifications of Aged or Disabled Adults. Incompetency is the diminished capacity of a person to understand, evaluate and appropriately respond to people, events and environments which effect or may be affected by him/her. One way to measure incompetency is by the use of the functional classifications. The DDA worker and the protective services worker must understand the concept of competency/incompetency to help in dealing with their clients. The following are the four functional classifications of disabled or aged adults.

(1) Self-determining: Mentally capable of caring for himself/herself and his/her interests; able to maintain at least minimal social standards of self-care and conduct.

(2) Marginally Competent: Partially capable of caring for himself/herself and his/her interests but able to maintain only minimal or intermittent levels of social functioning by reason of mental disorder or mental and/or physical malfunction.

(3) Incompetent: Mentally incapable of caring for himself/herself and his/her interests; unable to maintain minimal social standards of self-care and conduct by reason of mental disorder or malfunction.

(4) An Incompetent At Risk: In immediate crisis; without help, he/she is dangerous to self or others.

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Appendix S

Flow Chart - Intake to Termination of a Protective Services Case

State of New York
Dept. of Social Services
Bulletin # 194

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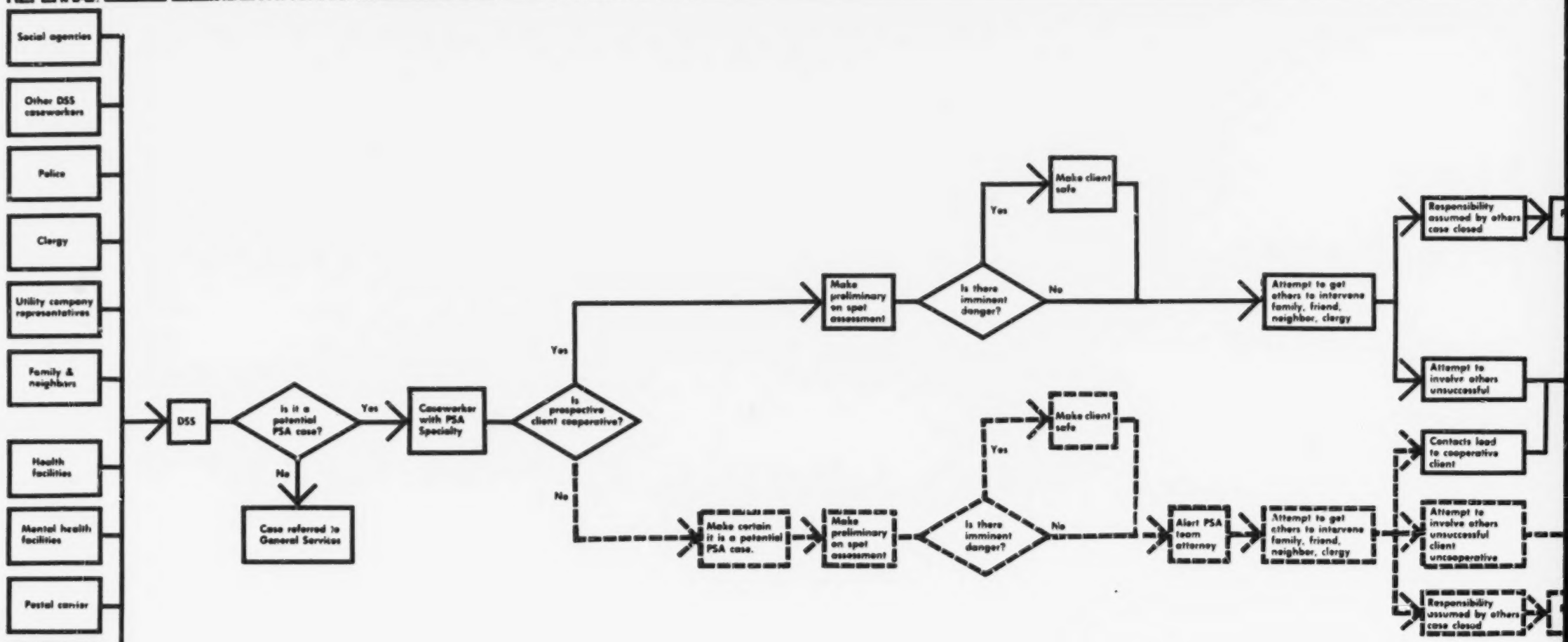

PROTECTIVE SERVICES FOR ADULTS: INTERVENTION PROCEDURES

■ COOPERATIVE

▪▪▪ UNCOOPERATIVE

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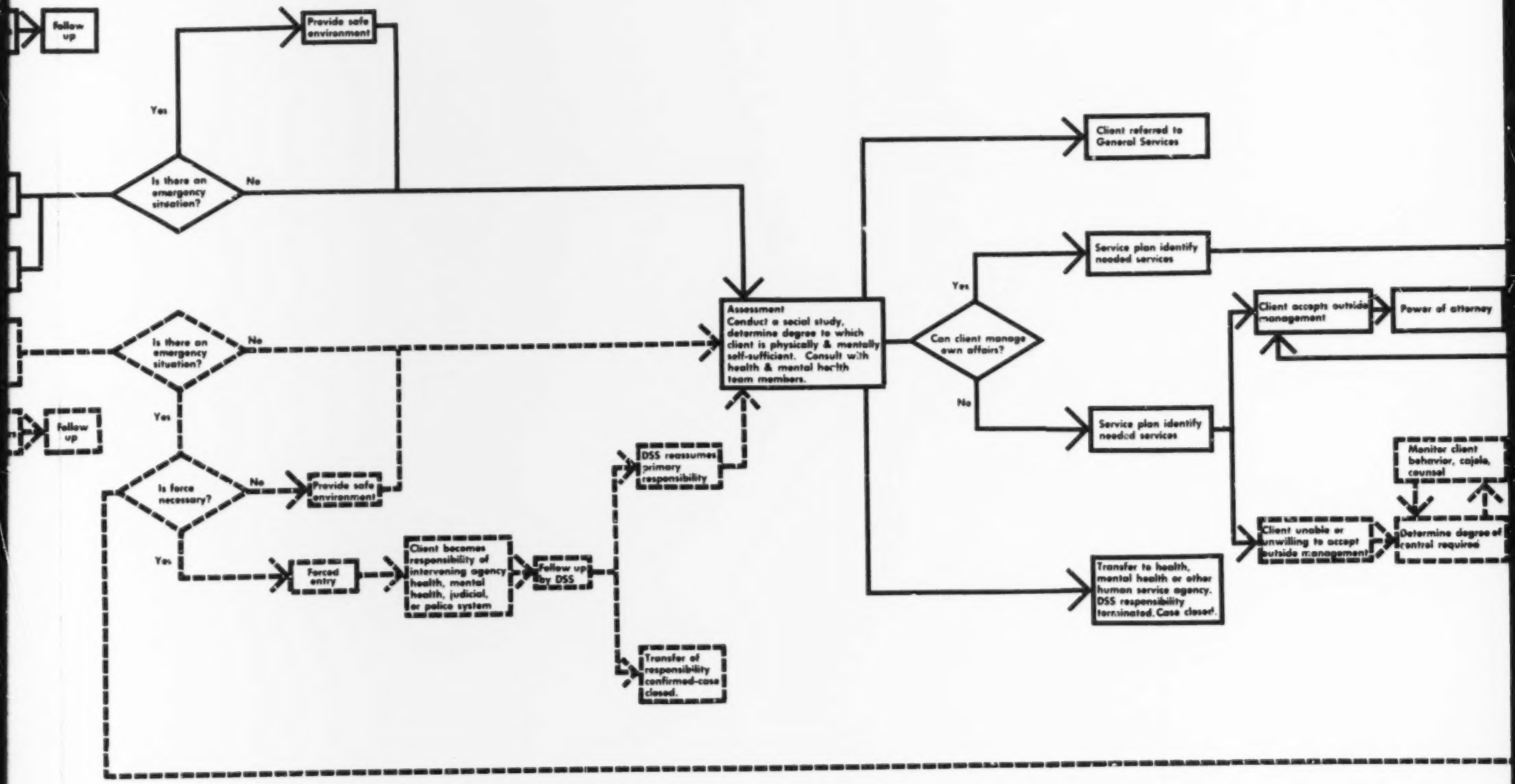
ERVENTION — ASSESSMENT and PLAN — PLAN-IMPLEMENTATIO


Follow up
Provide safe environment
Yes
Is there an emergency situation?
No
Client referred to General Services
Service plan identify needed services
Yes
Assessment
Conduct a social study, determine degree to which client is physically & mentally self-sufficient. Consult with health & mental health team members.
Can client manage own affairs?
Client accepts outside management
Power of attorney
No
Service plan identify needed services
Monitor client behavior, cajole, counsel
Client unable or unwilling to accept outside management
Determine degree of control required
Transfer to health, mental health or other human service agency. DSS responsibility terminated. Case closed.
Follow up
Is there an emergency situation?
No
Yes
Is force necessary?
No
Provide safe environment
Yes
Forced entry
Client becomes responsibility of intervening agency health, mental health, judicial, or police system
Follow up by DSS
DSS reassumes primary responsibility
Transfer of responsibility confirmed-case closed.

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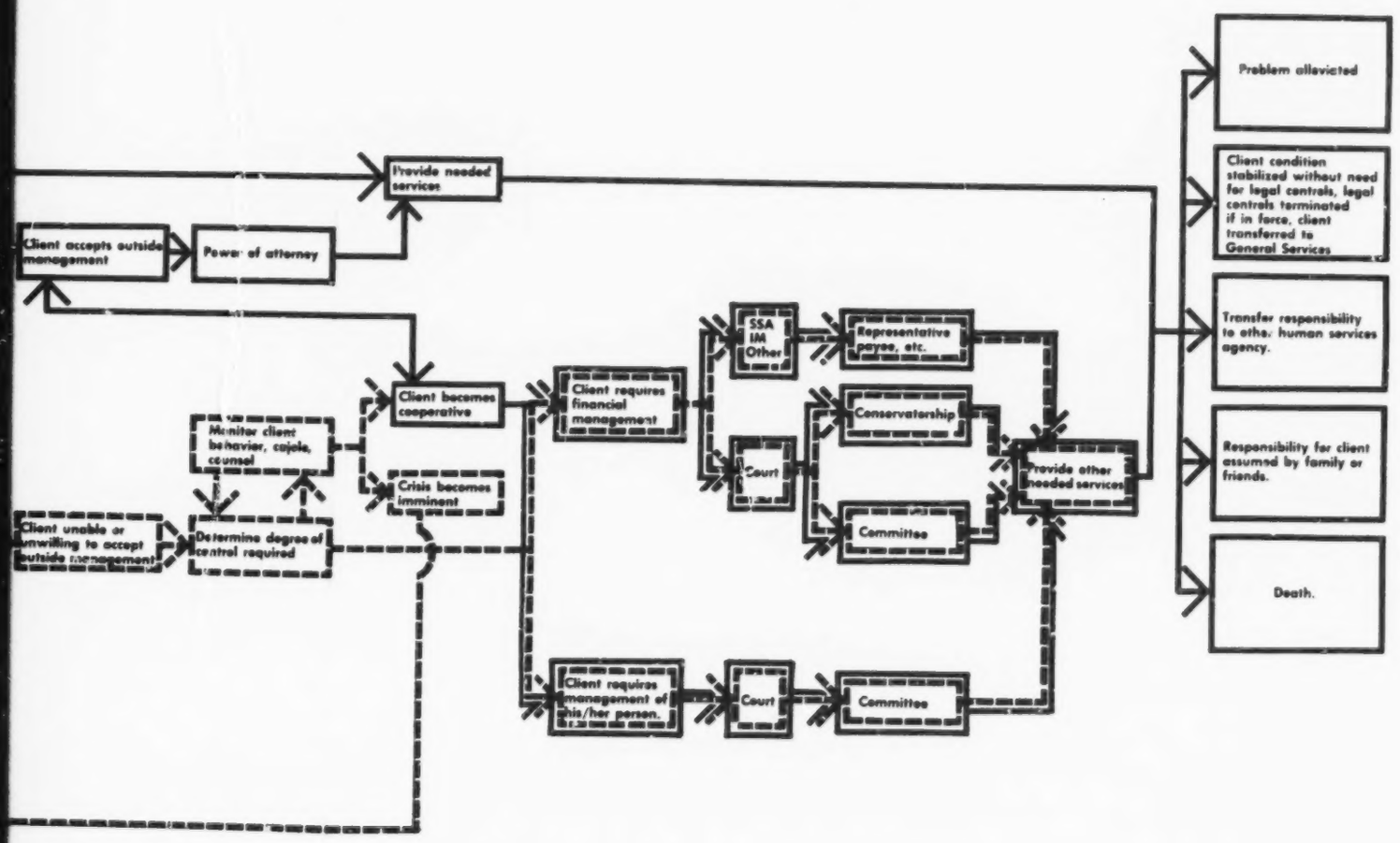
APPENDIX "S"

PLAN-IMPLEMENTATION — CASE TERMINATION



Appendix T

Cumulative Impairment Score - Rating Client's
Ability to Function in a Social Setting

State of Utah
Department of Social Services
Division of Family Services
Adult Protective Services
VPIA - 22 - VPIA - 250

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State of Utah
Department of Social Services
Division of Family Services
Adult Protective Services
VPIA 200 - VPIA250

Rating Client's Ability to Function in Social Setting
Cumulative Impairment Scale

DECISION MAKING SCALE

RATE THE CURRENT DECISION MAKING ABILITY OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING.

1. Excellent decision making skills.
Totally capable of making independent decisions regarding all facets of life.

2. Good decision making skills.

Capable of making all decisions regarding all facets of life.

5. Mildly impaired decision making skills.
Capable of making decisions about all facets of life with the periodic help of another person.

10. Moderately impaired decision making skills.
Adult's decisions are poor, can get by with the constant help of another adult.

15. Severely impaired decision making ability.
Adult either refuses to make decisions regarding life-threatening situations and refuses help from others, or makes inappropriate decisions which places the adult in life-threatening situations.

20. Totally unable to make decisions.
Adult is incontinent, unconscious or psychotic, and cannot even communicate about decisions.

RATING EVALUATION

7-14	Excellent Condition
15-31	Adult could use supportive services on a voluntary basis.
32-48	Adult needs a serious evaluation as capacity to make the decision to decline the use of protective services is questionable.
49-74	Adult requires protective services as the adult is incapacitated. File petition if the adult refuses to accept services voluntarily. File a petition for guardianship if other measures are unsuccessful.
75-95	Adult is totally incapacitated; file for guardianship. If necessary file for temporary guardianship in an emergency.

MENTAL HEALTH RATING SCALE

(RATE THE CURRENT MENTAL FUNCTIONING OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING.

1. Outstanding mental health.
Intellectually alert and clearly enjoying life. Manages routine and major problems in his life with ease and is free from any psychiatric symptoms.

2. Good mental health.
Handles both routine and major problems in his life satisfactorily and is intellectually intact and free of psychiatric symptoms.

4. Mildly mentally impaired.
Has mild psychiatric symptoms and/or mild intellectual impairment. Continues to handle routine, though not major problems in his life satisfactorily.

7. Moderately mentally impaired.
Has definite psychiatric symptoms, and/or moderate intellectual impairment. Able to make routine, common-sense decisions, but unable to handle major problems in his life.

15. Severely mentally impaired.
Has severe psychiatric symptoms and/or severe intellectual impairment, which interfere with routine judgments and decision making in every day life.

20. Completely mentally impaired.
Grossly psychotic or completely impaired intellectually. Requires either intermittent or constant supervision because of clearly abnormal or potentially harmful behavior.

ECONOMIC RESOURCES AND UTILIZATION SCALE

RATE THE CURRENT ECONOMIC RESOURCES AND UTILIZATION OF AND BY THE ADULT BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT CIRCUMSTANCES.

1. Economic resources and utilization are excellent. Ample income, used prudently.

2. Economic resources and utilization are satisfactory. Adequate income used appropriately.

4. Economic resources satisfactory and utilization is mildly impaired. Income is adequate: adult unable by poor management to meet fiscal responsibilities.

4. Economic resources moderately impaired and utilization is satisfactory. Income is inadequate; adult is able to manage with great effort.

9. Economic resources severely impaired. Utilization impaired. Adult either has a severely limited income or adult's income is being exploited by others. Adult fails to do anything to gain further income or stop the exploitation but is capable of doing so.

10. Economic resources and utilization totally impaired. The adult has no income or all funds have been stolen from him by friends or relatives. No utilization is possible as adult is incapable of obtaining income or stopping exploitation.

PHYSICAL HEALTH RATING SCALE

(RATE THE CURRENT PHYSICAL FUNCTIONING OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING.)

1. In excellent physical health.
   Engages in vigorous physical activity, either regularly or at least from time to time.

2. In good physical health.
   No significant illnesses or disabilities. Only routine medical care such as annual check ups required.

4. Mildly physically impaired.
   Has only minor illnesses and/or disabilities which might benefit from medical treatment or corrective measures.

6. Moderately physically impaired.
   Has one or more disseases or disabilities which are either painful or which require substantial medical treatment.

9. Severely physically impaired.
   Has one or more illnesses or disabilities which are either severely painful or life threatening, or which require extensive medical treatment.

10. Totally physically impaired.
    Confined to bed and requiring full time medical assistance or nursing care to maintain vital bodily functions.

ENVIRONMENTAL CONDITIONS

(RATE THE PERFORMANCE OF THE PERSON BEING EVALUATED ON THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PRESENT SITUATION).

1. Excellent Environment
   Living facility is in excellent condition and is in pleasant, safe location.

2. Satisfactory Enrironment
   Living facility is in good condition and is in a reasonable safe location.

4. Reasonable Environment
   Living facility is in a deteriorated building, but is adequately cared for in a reasonable safe location.

7. Potentially unsafe environment
   Living facility is in a deteriorated building and is poorly cared for and is in an unpleasant but reasonably safe location.

9. Unsafe Environment
   Living facility is unclean and unsanitary, water and bathroom is available but bathroom is filthy. Health Department might condemn the property. Location of facility is either (1) In an unsafe high-crime area. (2) An isolated area in rural Utah.

10. Dangerous environment
    Living facility is dilapidated, bathroom is not usable, water supply unsanitary or unavailable, infested with rats, or untrained cats or dogs. Health Department would condemn the property. Property is in unsafe, high-crime area, or in an isolated area in rural Utah.

SOCIAL RESOURCES RATING SCALE

(RATE THE CURRENT SOCIAL RESOURCES OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT CIRCUMSTANCES.)

1. Excellent social resources.
   Social relationships are very satisfying and extensive; at least one person would take care of him (her) indefinitely.

2. Good social resources.
   Social relationships are fairly satisfying and adequate and at least one person would take care of him (her) indefinitely.

6. Mildly socially impaired.
   Social relationships are unsatisfactory, of poor quality, few; but at least one person would take care of him (her) indefinitely or on a short term basis.

8. Moderately socially impaired.
   Social relationships are unsatisfactory, of poor quality, few; and only short term care is available.

9. Severely socially impaired.
   Social relationships are unsatisfactory, or poor quality, and harmful to the adult's physical and fiscal situation.

10. Totally socially impaired.
    Social relationships are non-existant.

ACTIVITIES OF DAILY LIVING

(RATE THE CURRENT PERFORMANCE OF THE PERSON BEING EVALUATED ON THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT PERFORMANCE.)

1. Excellent ADL capacity.
   Can perform all the activities of Daily Living without assistance and with ease.

2. Good ADL capacity.
   Can perform all of the Activities of Daily Living without assistance.

4. Mildly impaired ADL capacity.
   Can perform all but one to three of the Activities of Daily Living. Some help is required with one to three, but not necessarily every day. Can get through any single day without help. Is able to prepare his own meals.

6. Moderately impaired ADL capacity.
   Regularly requires assistance with at least four activities of Daily Living but is able to get through any single day without help. Or regularly requires help with meal preparation.

8. Severely impaired ADL capacity.
   Needs help each day but not necessarily throughout the day or night with many of the Activities of Daily Living.

10. Completely impaired ADL capacity.
    Needs help throughout the day and/or night to carry out the Activities of Daily Living.

SUMMARY OF RATINGS

Social Resources _____

Economic Resources _____

Environmental Conditions _____

Mental Health _____

Physical Health _____

Activities of Daily Living _____

Decision Making _____

Cumulative Impairment Score (Sum of the five ratings) _____

Appendix U

A Guide on Protective Services for Older People

Administration on Aging
Office of Human Development Services
Department of Health and Human Services

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Appendix U

ADMINISTRATION ON AGING

A Guide on
Protective Services for Older Persons

INTRODUCTION

This guide in the form of questions and answers is intended to provide the reader with a clear understanding what Protective Service for Older Persons is; to whom it applies; what are its components; when it can be used and for what purposes and where it is available.

1. Q. What is Protective Service?

   A. Protective Service is a social service with medical and legal aspects provided to an older person, who, as a result of physical or mental dysfunction (or both), abuse, neglect or extreme social or economic need is at risk of harm to self or to thers. The purpose of Protective Service is to protect that older person from such harm, by stabilizing his (or her) situation in order to maintain him in the least restrictive setting, or by providing institutional care where it is needed. Community Protective Service involves casework services and occasionally medical and legal interventions. Medical interventions are needed to identify the type and severity of functional disability and abuse and neglect (physical, emotional, mental). Legal interventions to protect the individual's money or his person may be required when the older individual appears unable or incompetent to use judgment or unable to make decisions for himself. These legal procedures may include conservatorship, guardianship, admission to a chronic care institution or commitment to a mental institution in the case of a seriously mentally impaired individual. Such legal procedures are necessary to authorize Protective Service intervention when an older person is unable or incompetent to authorize or consent to protective service intervention himself.

2. Q. What is unique about Protective Service?

   A. It is a social service to obtain, provide and coordinate social, medical and legal interventions on behalf of incapacitated individuals at risk of harm to self or to others. Social casework is the core service. It is unique in its necessary utilization of medical care programs accountable to the protective service system and in its necessary utilization of legal authority as part of the protective service process.

3. Q. What are the Components of a Comprehensive Protective Service?

   A. The components of a comprehensive protective service include:

   Social Components - Casework and supportive counselling
   Case Management and managing the Protective Service Actions.
   Resource Development - Family and Community
   Provision of Discrete Social Services as needed:
   (e.g. homemaker, chore, meals, transportation, Information and Referral, etc.)

Medical Components - Medical Care - diagnosis, treatment and continuing supervision
Nursing Care appropriate to the situation provided when and where needed
Personal Care as needed

Legal Components - Use of Legal Interventions and Procedures such as: conservatorship of funds and guardianship over the person or property; arranging and participating in competency hearings; representation of older persons and protection of their civil rights.

4. Q. How can these Protective Services help older persons?

A. Protective Services can:

- Intervene in crises or stressful situations dangerous to the individual by assuring immediate, appropriate action to stabilize and normalize the situation and by arranging for necessary surveillance, care and ongoing supervision until a permanent solution is found.

- Anticipate developing incapacities in physical, mental or emotional functioning (i.e. frailty, anxiety, depression) and undertake preventive and remedial actions to protect the individual. Such actions might include assisting older persons to leave settings which enforce loneliness and isolation, encouraging their participation in Senior Centers or other group activities and arranging for supportive services on an on-going basis from appropriate community agencies.

- Protect an older person from neglect, exploitation or abuse by others by calling upon other social, medical, legal and law enforcement resources as necessary support.

- Protect a competent individual no longer capable of living independently in a community setting, by helping him obtain social and health supportive services in home when preferred or choose a voluntary institutional placement or a group living arrangement.

- Protect an older person's funds so that he (she) will not be exploited by others to spend limited funds foolishly, or not spend them at all. This protection occurs through establishing administrative and financial arrangements like representative payee or legal protections like conservatorship.

- Protect older persons whose life style or bizarre conduct raises concern in the community demanding public intervention. Protection can be provided by developing a helpful and trusting relationship with such individuals thus enabling them to call for help or accept protective intervention when needed.

5. Q. Who provides Protective Service?

   A. Protective Service programs are normally provided by public and private licensed Social Agencies at the local community level. These services may be provided by direct service staff of these public or private Service Agencies. They may also be provided by private agencies under contract to public agencies, which meet appropriate State licensure standards.

6. Q. When are social, medical or legal interventions necessary?

   A. Starting from the assumption that an older person is competent unless otherwise indicated, such interventions are needed when an older person cannot carry out normal everyday personal and economic functions without help from others, as determined by appropriate assessment and evaluation of his condition and is in substantial risk of harm as determined by socio/medical assessments. Social or legal interventions may be necessary.

7. Q. How is an older person determined to be "incapacitated"?

   A. Usually by a socio/medical diagnosis or assessment of his functional capacity to carry out the ordinary activities of daily living without help from others. A person is deemed competent who is legally qualified or capable of making decisions or taking independently actions in his own behalf. "Incapacitated refers to the deprivation (for whatever reason) of the normal capacity to make decisions, etc." Incompetency means not legally qualified (as determined by the Court), to make decisions or to take actions on one's own behalf. Incapacity in this case is medically determined and may be the basis for a Court hearing to determine legal competence or incompetence.

8. Q. What role can the family play in the protective service process?

   A. Older persons should be considered self determining unless there is evidence to the contrary. In such instances family members are usually the ones who assume the protective role. If there are no family members available and ready, willing and able to assume this responsibility for the older person, the Public Social Agency may have to assume this responsibility. An older person who is competent but frail may request assistance of a protective nature. An older person who is "incapacitated" may be directed or referred for help to the Public Social Agency or the Private Social Agency licensed to provide protective assistance. In any case, the family, if available, should always be involved in protective social or legal intervention.

9. Q. How are personal rights of incapacitated" clients who are referred by the caseworker to the Court for a hearing on competency protected?

A. By providing the client with meaningful notice, including individual counselling and discussion to obtain his understanding and preferences, if possible, as preparation for a meaningful opportunity to participate in the hearing process. If there is any question that an older person is not in agreement with the determination of incompetency or of the outcomes planned then he should be referred to a legal services program.

Interaction between caseworker and agency lawyer enhances the possibilities for a proper socio/legal intervention. Their activities are guided by a medical status report on the client which becomes part of the basis for the Court's determination of competency or incompetency.

The older person should be present at any Court Proceeding to determine competency. The older person should be represented by legal counsel at such a hearing. The social worker would normally be present if the older person were a client.

10. Q. What is the difference between Legal Services under the Older Americans Act and Protective Service for Older Persons?

A. Legal Services under the Older Americans Act include legal advice, counselling and representation provided to an older person with economic or social need by an attorney or a legal service worker acting under the supervision of an attorney.

Legal services involve types of clients who extend beyond the particular group needing protective services.

Some differences between legal services and protective services are:

A. Legal services are based upon an attorney-client relationship. Protective Service is a multi-diciplinary activity involving social workers, physicians and lawyers.

B. The purpose of legal services is to protect and advance the legal rights and interests of older persons in legal matters such as public entitlements, housing, health care, employment, property interests and the right to be free from age and other forms of discrimination. The purpose of Protective Service is to protect a functionally impaired older person or one who is abused, neglected or exploited from risk of harm to self or others.

C. The basis for provision of legal services is a request for service to an attorney by an older person or by someone acting on behalf of the older person. Protective Services are the result of a direct intervention by a State/or Local Department

of Social Services or by a licensed Social Service Agency. The basis for such intervention is to protect the individual from risk of harm to self or by others. Legal interventions are activities undertaken on behalf of a Social Agency or an individual family member, seeking to establish legal authority to take action or to make decisions to protect the safety or welfare of an older person. Such interventions are carried out when the Social Agency utilizes legal counsel to approach the Court to appoint a conservator for an older client, to protect their money.

D. In as much as legal proceedings to establish surrogate authority (conservatorship - above) of necessity involve different legal interests than those identified under legal services above it is generally inappropriate for a legal services program to represent a Social Agency (or an individual family member) seeking surrogate authority over an older person. When a Social Agency uses legal counsel to undertake such an intervention that counsel is acting as a representative of the Social Agency. A Legal Service attorney would represent the interests and protect the civil rights of the older person who is the subject of the protective action undertaken by the Social Agency.

Once a legal intervention is completed, giving legal authority over an older person to a surrogate decision maker (the conservator) the conservator may seek legal services from a Legal Services Agency for the incapacitated older person. The Legal Services provider may establish an attorney-client relationship with the older person through that conservator.

11. Q. What are the common legal procedures available to protect the money or the person of a "legally competent" older person?

A. Conservatorship, Guardianship (various forms) and voluntary or involuntary Commitment to a mental or other institution.

12. Q. How are these legal procedures triggered?

A. By a petition to a Court of competent jurisdiction for a competency hearing. This request can be initiated by an interested party including a relative, a Social Agency, a public official or a private physician.

13. Q. What is Conservatorship?

A. Conservatorship is a trust relationship in the broadest sense, created when one person, selected by the Court, is entrusted by a court order with the management of the financial assets of another person (or of his person). A conservatorship is normally requested when the person's physical or mental health is such that he (or she) cannot care for, conserve, nor properly use any real or personal property which he (or she) may own.

14. Q. What is Guardianship?

A. Guardianship is a legal procedure directed to protection of the person of an incompetent or incapacitated adult (as defined in State statutes) or to protection of his estate. Public Guardianship is a legal procedure carried out by an office of State Government specifically established under state law for the purpose of protecting the person or the estate (or both) of incompetent persons.

15. Q. What is Commitment to a Mental or other Institution?

A. This is an action by the Court, under appropriate state statutes, to place an individual determined by the Court to be incompetent in an institution for care and treatment for a period of time determined by the court. Such an action may be undertaken at the individual's behest (voluntary commitment) or without the individual's approval (involuntary).

16. Q. What agencies in the community normally are available to help older persons or their families in considering the need for Protective Service?

A. Area Agencies on Aging, County Departments of Social Service and their State counterparts; Law Enforcement Agencies, Family Service Agencies, United Way Agencies, Legal Services Agencies and Information and Referral Agencies are among the agencies available for this purpose. Such agencies may provide protective service directly, contract for the provision of protective service or refer to agencies providing protective service.

17. Q. How is Protective Service Funded?

A. Funds to underwrite protective service programs may be available from public sources (Title XX of the Social Security Act; Title III of the Older Americans Act); or private sources (United Way; private foundations). Social Agencies, both Public and Private, may provide protective service to older persons without cost or they may charge a fee for service. This is a matter of agency policy.

CASE EXAMPLES

A. Crisis Case - Disturbed Behavior

"Mrs K., age 80, was found found by police wandering in the streets. She was disoriented as to time and place and did not know where she lived. She was obsessed by the delusion that cars passing in the street were calling her name and that she must go to them. She refused to respond to questions or attempts to discuss her situation with her."

Comment: Preliminary assessment to determine if the client requires a court hearing to determine competency and appropriate placement.

B. Physical Impairment

"Mr. L., age 80, living alone without known relatives in the midst of accumulated debris, was referred to Protective Service by an opthalmologist who found Mr. L's blood pressure so high he feared stroke. Protective Services staff's immediate responsibility was to persuade him to enter a hospital and assist him in the necessary preparations, so that blood pressure could be reduced and he could be prepared for cataract surgery."

Comment: Involves counselling and placement in hospital plus later provision of support service at home to avoid unnecessary institutionalization.

C. Request for Service

"A woman, 76 years of age, was in an emotional state described as "frantic" when referred by the office of a U.S. Senator. She was mentally alert and able to function in her own apartment. Her income was $240 per month. Social Security benefit. A rent increase of $100 per month meant she did not have enough income to meet other living expenses. She had been unable to find cheaper quarters where she felt secure. Her savings were exhausted. Fear and a sense of having to face an impossible life situation alone resulted in panic."

Comment: Need for conferring with Social Security authorities and with local housing authorities to develop solutions. Counselling to deal with emotional disturbance. Referral to legal services on rights to public benefits and rights as a tenant.

Table I

States providing Adult Protective Services under Title XX of the Social Security Act*

State	Number of Recipients	Total Cost
Alabama	275	$ 58,115
Alaska	371	262,706
Arizona	1,218	173,448
Arkansas	38	11,985
California	33,473	6,973,380
Colorado	2,477	276,305
Connecticut	6,030	1,675,974
District of Columbia	24	15,871
Florida	577	110,669
Georgia	1,498	880,467
Hawaii	283	181,658
Idaho	599	105,717
Illinois	3,061	712,447
Indiana	2,900	142,896
Iowa	647	39,036
Kentucky	565	50,853
Louisiana	1,393	133,963
Massachusetts	3,782	552,337
Michigan	9,537	4,809,861
Minnesota	4,980	593,743
Mississippi	3,758	167,109
Missouri	2	79
Montana	7,465	324,575
Nebraska	319	64,206
Nevada	123	51,920
New Hampshire	149	45,319
New Jersey	4,673	324,539
New Mexico	260	40,396
New York	3,562	1,480,399
North Carolina	1,125	87,293
Ohio	3,333	639,538
Oklahoma	1,010	152,463
Oregon	1,121	27,487
Pennsylvania	1,752	62,808
Rhode Island	100	53,037
South Carolina	757	148,231
South Dakota	115	7,664
Tennessee	2,482	350,582
Texas	7,204	907,162
Utah	1,693	343,852
Vermont	386	50,549
Virginia	1,448	178,035
Washington	952	181,929
Wisconsin	9,864	329,488
Wyoming	1,892	123,937

*SSRR Report, 3d Quarter, FY 1978. Statistical Table No 4. OHDS, HHS, National Summary of Services provided to Primary Recipients.

Table II

Number of Primary Recipients of Adult Protective Service under Title XX.
By Service, Recipient Category, Method of Provision and by Cost.

Service	Total Recipients	% Income Eligibles	% SSI	% Without Regard to Income	% Other*
	Recipient Category				
Adult Protective Service	138,510	17	31	37	15

Service	Direct Provision		Purchase—Public		Purchase—Private**	
	Costs	% of Total	Costs	% of Total	Costs	% of Total
	Method of Service Provision					
Adult Protective Service	$52.6m.	81	$9.6 million	15	$2.6 million	4

Service	Total Cost	% Income Eligibles	% SSI	% Without Regard to Income	% Other*
	Cost				
Adult Protective Service	$95,697,967	12	30	41	17

Source: Technical Notes on Social Service Reporting Requirements. (SSRR Data)
*App. 1, p. 4, No. of Primary Recipients of SS under Title XX, IVA & CWS by quarter, July–September 1978.
**App. P Costs of SS under Title XX, etc., by Method of Provision, by service, Oct. '77–Sept. '78.
***App. M Costs of SS under Title XX, etc.; by service, by recipient category, Oct. '77–Sept. '78.

Table III

States with Adult Protective Service Laws

State	DATE
Alabama	1977
Arizona	1980
Arkansas	1977
Connecticut	1978
Florida	1977
Kansas	1980*
Kentucky	1980 (Rev.)
Maine	
Maryland	1977
Michigan	1976/78
Minnesota	1980**
Mississippi	1980
Montana	
Nebraska	**
New Hampshire	1977
New York	1979
North Carolina	
Oklahoma	1977**
Oregon	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Utah	1977
Vermont	1980
Virginia	1977
West Virginia	
Washington	1973

* Limited to Individuals in Nursing Homes
** Reporting Law only
*** Elderly Only

Source: U.S. Senate/House Committees on Aging - Hearings on Elder Abuse, June 1980, Washington, D.C. 96th C. 2d Sess. See Appendix #4 Survey of States.

Table IV

Directory of State Offices Responsible for Adult Protective Services: *

ALABAMA
State Department of Pensions and Security
Bureau of Adult Services
64 North Union Street
Montgomery, Alabama 36130

ALASKA
Division of Social Services
Department of Health and Social Services, Pouch H-05
Juneau, Alaska 99811

ARIZONA
Aging and Adult Administration
1400 West Washington
Phoenix, Arizona 85007

ARKANSAS
Adult Protective Services
Donaghey Building, Rm. 1428
Little Rock, Arkansas 72201

CALIFORNIA
Department of Social Services
Adult PROTECTIVE Supportive Services Bureau
744 P Streeet M.S. 5-141
Sacramento, California 95814

COLORADO
Colorado State Department of Social Services
Adult Programs
1575 Sherman
Denver, Colorado 80203

CONNECTICUT
State of Connecticut
Department on Aging
90 Washington Street
Hartford, Connecticut

DELAWARE
Department of Health and Social Services
New Castle, Delaware 19720

DISTRICT OF COLUMBIA
Protective Services for Adults
Room 613
122 C Street, N. W.
Washington, D. C. 20001

FLORIDA
Aging and Adult Services Program Office
1317 Winewood Blvd.
Tallahassee, Florida 32301

GEORGIA
Division of Family and Children's Services
Social Services Section
618 Ponce de Leon Avenue
Atlanta, Georgia 30308

HAWAII
Social Services Intake Unit
1149 Bethel Street, Room 400
Honolulu, Hawaii 96813

IDAHO
State of Idaho
Division of Welfare
Statehouse
Boise, Idaho 83720

ILLINOIS
State Agency on Aging
421 E. Capitol Avenue
Springfield, Ill. 62706

INDIANA
Commission on Aging and Aged
Graphic Arts Building
215 North Senate Avenue
Indianapolis, Indiana 46202

IOWA
Bureau of Adult Services
Hoover State Office Building
Des Moines, Iowa

KANSAS
Adult Services Section
State Department of Social Services
Biddle Building, 1st Floor
2700 West 6th
Topeka, Kansas 66606

KENTUCKY
Department for Human Resources
Division for Aging Services
Alternate Care Branch
275 E. Maine Street, 6th Floor W.
Frankfort, Kentucky 40601

LOUISIANA
Division of Evaluation and Services
P.O. Box 3318
Baton Rouge, Louisiana 70821

MAINE
Adult Protective Services
Department of Human Services Bureau of Resources Development, Station 11
State House
Augusta, Maine 04333

MARYLAND
State Social Services Administration
Adult Protective Services
11 South Street
Baltimore, Maryland 21212

MASSACHUSETTS
Department of Social Services
11th Floor
150 Causeway Street
Boston, Massachusetts 02114

* Source : Appendix VIII. Report on 'Elder Abuse' Select Cte on Aging
U.S. House of Representatives. Apr 3, 1981
Committee Print # 97 - 277

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MICHIGAN
Office of Adult and Family Community Services
Adult Protective Services Division
300 South Capitol Avenue
P.O. Box 30037, Suite 707
Commerce Center Building
Lansing, Michigan 48910

MINNESOTA
State of Minnesota
Department of Public Welfare
Centennial Office Building
St. Paul, Minnesota 55155

MISSISSIPPI
Department of Public Welfare
Jackson, Mississippi

MISSOURI
Missouri Division of Aging
P.O. Box 570
Broadway Office Building
Jefferson City, Missouri 65102

MONTANA
Dept. of Social and Rehabilitative Services
Social Services Division
Box 4210
Helena, Montana 59601

NEBRASKA
Division of Social Services
Adult Service Unit
Nebraska Department of Public Welfare
Lincoln, Nebraska 68509

NEVADA
Nevada State Welfare Division
251 Jeanell Drive
Carson City, Nevada 89710

NEW HAMPSHIRE
Division of Welfare
Bureau of Adult Services
Hazen Drive
Concord, New Hampshire

NEW JERSEY
Dept. of Human Services
Div. of Youth and Family Services
Trenton, New Jersey 08625

NEW MEXICO
Field Services Bureau
Social Services Division
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87503

NEW YORK
New York State Dept. of Social Services
Aging Services Section
40 North Pearl St.
Albany, New York 12243

NORTH CAROLINA
North Carolina Division of Social Services
325 North Salisbury Street
Raleigh, North Carolina 27611

NORTH DAKOTA
Social Service Board
State Capitol
Bismark, North Dakota

OHIO
Bureau of Adult Services
Ohio Department of Public Welfare
30 East Broad Street
Columbus, Ohio 43215

OKLAHOMA
Department of Human Services
Division of Services to Adults and Families
P.O. Box 25352
Oklahoma City, Oklahoma 73125

OREGON
Adult and Family Services
Department of Human Resources
400 Public Services Building
Salem, Oregon

PENNSYLVANIA
Department of Public Welfare
Room 533
Health and Welfare Building
Harrisburg, Pennsylvania 17120

RHODE ISLAND
Family and Adult Services
600 New London Avenue
Cranston, Rhode Island 02920

SOUTH CAROLINA
Adult Services Division
Adult Protective Services Unit
State Department of Social Services
Box 1520
Columbia, South Carolina 29202

SOUTH DAKOTA
Office of Adult Services
Kneip Building, Illinois Street
Pierre, South Dakota 57501

TENNESSEE
Tennessee Department of Human Services
Division of Social Services
Proactive Services for Adults
111-19 7th Avenue North
Nashville, Tennessee 37203

TEXAS
Alternate Care for Aged and Disabled Adults Division
Texas Department of Human Resources
P.O. Box 2960
Austin, Texas 78769

UTAH
State Division of Aging
150 West North Temple 4326
P.O. Box 2500
Salt Lake City, Utah 84103

VERMONT
Department of Health
60 Main Street
Burlington, Vermont 05401

VIRGINIA
Virginia State Department of Welfare
8007 Discovery Drive
Richmond, Virginia 23228

WASHINGTON
Bureau of Aging
OB-43G
Olympia, Washington 98504

WEST VIRGINIA
All Welfare Department Area Offices

WISCONSIN
Adult Service Units in 72 counties

WYOMING
Wyoming Department of Health and Social Services
Division of Public Assistance and Social Services
Hathaway Building
Cheyenne, Wyoming 82002

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